Utilization Review Standards Regulations	COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.8(a)(3); 9792.8(a)(3)(B)	Commenter is concerned that these requirements are a possible copyright infringement.	**Julie K. Johnson**, Assistant Vice-President of Medical and Disability Services, **Liberty Mutual** December 8. 2004 Written comment	We disagree. Title 17 U.S.C.S. section 107 identifies four prongs which must be considered when considering the issue of whether there has been a violation of federal copyright law: (1) the purpose and character of the use, including whether such use is of a commercial nature or is for nonprofit educational purposes; (2) the nature of the copyrighted work; (3) the amount and substantiality of the portion used in relation to the copyrighted work as a whole; and (4) the effect of the use upon the potential market for or value of the copyrighted work. The Doctrine of Fair Use, however, can protect such use in this context. Providing written copies of relevant sections of applicable copyrighted guidelines with respect to Labor Code section 4610 utilization review is probably protected under the Doctrine of Fair Use. In addition, the Nimmer Treatise on Copyright and its analysis of the concept of "fragmented literal similarity" indicates that such use would probably not be construed as copyright infringement.	None

			Labor Code sections 4610(f)(4) and 4610(f)(5) require that the criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services be disclosed to the physician and *the employee*. It is well within the statutory authority of Labor Code section 4610 to interpret the "disclosure" language in subdivisions (f)(4) and (f)(5) to mean that a copy of the relevant criteria or guidelines should be given rather than just a description of the guideline. The language within subdivision (f)(5) relating to charging copying costs, and making criteria or guidelines available through electronic means also supports the interpretation that the statute intends that a copy of the relevant criteria or guidelines be sent to the physician and employee.	
General comment	Commenter is further concerned about the potential negative impact to the doctor-patient relationship. Commenter states that the injured worker may believe there is an entitlement to receive all treatments/services listed in the guideline, whether or not they have been ordered by their doctor or are clinically indicated in their specific case. Commenter believes this has the potential for driving medical costs higher and creating undue injured worker concern regarding the care rendered by their doctor.		We disagree. Labor Code section 4610 requires that the guidelines or criteria be *disclosed to the injured worker*. Labor Code section 4610 subdivision (f)(4) states as follows: (f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:	None

			(4) Disclosed to the physician and *the employee*, if used as the basis of a decision to modify, delay, or deny services in a specified case under review. Finally, with regard to the concern that obtaining licenses for "other evidence based medical treatment guidelines" under Labor Code section 4604.5(e), would be an extraordinary fiscal responsibility, it is believed that where a claims administrator utilizes "other evidence based guidelines," it is the responsibility of the claims administrator to obtain the necessary license agreements to allow disclosure of the specific criteria or guidelines used to disapprove or modify the particular treatment. The utilization review statute contemplates that such costs for obtaining licenses would be borne by the claims administrator and not by the physicians or injured workers. The regulations, therefore, as currently written have not exceeded the scope of the statute. As indicated above, this requirement is directed by Labor Code section 4610.	None.
	Commenter is further concerned with the letter generation process that would be required to comply with the requirement to include a copy of the relevant portion of the guideline in determination letters. Commenter states that the requirement as currently written would require a time consuming and costly manual process.			

Section 9792.9	Commenter indicates that section 9792.9 requires the "claims administrator" to issue notices and perform other administrative activities However, in many claims operations, both for insurance companies and TPAs, the Utilization Review function is done under a contract with an outside vendor who in almost all instances provides the required notices on behalf of the claims administrator.	**Stuart Baron, Esquire** December 23, 2004 Written comment	We agree. Labor Code section 4610(b) allows the employer to contract with outside vendors to conduct its utilization review responsibilities.	Section 9792.6(b) setting forth the definition of "claims administrator" has been amended to indicate that the claims administrator may utilize an entity with which an employer or insurer contracts to conduct its utilization review responsibilities.
Section 9792.9(b)(3)	Commenter is concerned about the requirement to send all approvals to the injured worker. Commenter believes that the section means that any decision, even those approved by non-physician reviewers, must be sent to the injured worker. This will involve a lot of work.	**Dolores McCarthy,** Manager, Utilization Review/Case Management Program Kaiser Permanente December 21, 2004 Written Comment	Agree. Upon closer review of Labor Code section 4610(g)(3), decisions to approve a physician's request for authorization for medical services must be communicated to the requesting physician but there is no requirement that the decision be communicated to the injured worker.	Section 9792.9(b)(3) has been amended to reflect that decisions to approve a physician's request for authorization prior to, or concurrent with, the provision of medical services to the injured worker shall be communicated to the requesting physician The provision requiring that the decision to approve be communicated to the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney has been deleted. Consistent with the language of Labor Code section 4610(g)(3), a new subdivision, 9792.9(b)(4), has been added to the

				regulations to clarify that decisions to modify, delay or deny the physician's request for authorization must be communicated to the physician and to the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.
Section 9792.6(b)	Commenter states that the regulation is not clear as to whether there is a distinction between a UR vendor's approval of treatment and a claims examiner's approval of treatment.		We agree. Labor Code section 4610(b) allows the employer to contract with outside vendors to conduct its utilization review responsibilities.	Section 9792.6(b) setting forth the definition of "claims administrator" has been amended to indicate that the claims administrator may utilize an entity with which an employer or insurer contracts to conduct its utilization review responsibilities.
Sections 9792.7(b)(2), 9792.7(b)(3)	Commenter states that these sections appear to contradict each other, and that based on the statute it is clear that an examiner or non-physician can approve but not modify, delay or deny treatment on the basis of medical necessity.		We disagree. Section 9792.7(b)(3) allows a non-physician to initially review the request for authorization of medical services and request additional information when necessary within the time limitations in the regulations. Section 9792.7(b)(2), on the other hand, clearly states that only a licensed physician may delay, modify or deny a request for authorization of medical services.	None.

Sections 9792.7(a)(1), 9792.7(b)(2)	Commenter indicates that it appears that the vast majority of physicians conducting utilization review are not licensed California physicians. Commenter objects to having his requests for surgical treatment being reviewed by physicians who are not licensed in the State of California and are not surgeons.	**George W. Balfour, M.D.** January 7, 2005 Written comment	Disagree. Labor Code section 4610(d) requires that the medical director responsible for the utilization review process hold an unrestricted license to practice medicine in the state of California. Labor Code section 4610(e), however, does not require the physician reviewer to have a California license; this section only requires that the reviewing physician be "a licensed physician who is competent to evaluate the specific clinical issue involved in the medical treatment services." These are the requirements set forth in the regulations at sections 9792.7(a)(1) and 9792(b)(2).	None.
Section 9792.9(i) – was re-lettered 9792.9(j)	Commenter has experienced unreasonable time frames. Would like the regulations to set forth a reasonable amount of time for a treating physician to respond to the physician reviewer to discuss the request for authorization of medical care.		We agree. It is reasonable that a physician reviewer provide the treating physician a reasonable amount of time for the treating physician to discuss the request for authorization of medical treatment.	Section 9792.9(j) has been amended to also require that the written decision shall also disclose the hours of availability of either the physician reviewer or the medical director for the treating physician to discuss the decision which shall be at a minimum four (4) hours per week Pacific Standard Time.

Section 9792.10	Commenter states that section 9792.10(a)(2) contains a clerical error because Labor Code 4062 allows an unrepresented injured worker 30 days, as opposed to 20 days for a represented worker to file an objection to a medial determination.	**Marianne McReynolds**, CPA, VP Finance **Horizon Managed Care LLC** February 1, 2005 Written comment	We disagree. Commenter is correct that Labor Code section 4062(a) provides that an unrepresented injured worker has 30 days, as opposed to 20 days, to object to a medical determination. However, Labor Code section 4062(a), as amended by SB 899, effective April 19, 2004, also contains the following specific language: "If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision. In other words, in the amended language in Labor Code section 4062 pursuant to SB 899, there is no differentiation between a represented injured worker and an unrepresented injured worker when objecting to a utilization review decision pursuant to Labor Code section 4610.	None.
Section 9792.9	Commenter states that the current time limits that are applied to the utilization review process in the regulations are very restrictive.	**Steven Rosen, M.D.** **CompParters** January 28, 2005 Written comment	Disagree. The time limits set forth in the regulations are derived from the statute. Specifically, Labor Code section 4610(g)(1) states, in pertinent part: "Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more	None.

			than 14 days from the date of the medical treatment recommendation by the physician."	
General Comment	Commenter requests that the regulations clarify who has requester rights for an intervention and for an appeal for a non-certification. Commenter indicates that it should be the requesting physician, and not the DME company, physical therapy vendor or patient. If one of these ask for an appeal and we call the attending physician, he will not have any idea what is going on and he will be blind sided by the peer reviewer.		Agree. Commenter is correct that only the treating physician may contact the UR reviewer to discuss the decision issued in connection with the request for authorization. Section 9792.9(k) has been amended, in relevant part, to clarify that the written decision modifying, delaying or denying treatment authorization provided to the physician disclose the hours of availability of either the physician reviewer or the medical director for the treating physician to discuss the decision which shall be at a minimum four (4) hours a week Pacific Time.	Section 9792.9(k) has been amended. The section now states: "The written decision modifying, delaying or denying treatment authorization provided to the physician shall also contain the name and specialty of the physician reviewer and the telephone number in the United States of the physician reviewer. The written decision shall also disclose the hours of availability of either the physician reviewer or the medical director for the treating physician to discuss the decision which shall be at a minimum four (4) hours a week Pacific Time."
Section 9792.9(a)	Commenter suggests that it be mandatory that the request for authorization be accompanied by current clinical progress notes and imaging, if necessary.		Agree in part. The regulations have been clarified to state that the request for authorization may be set forth in a narrative form containing the same information required in Form DLSR 5021 or PR-2, which requires reporting on current clinical progress. We disagree that imaging should	Section 9792.6(m) has been amended, in pertinent part, to state that both the written confirmation of an oral request and the written request must be set forth in Form DLSR 5021,

			always accompany the request for authorization because the physician will not always know whether the physician utilization reviewer will consider imaging necessary and if necessary; the imaging can always be requested.	section 14006, or in the Primary Treating Physician Progress Report DWC Form PR-2, section 9785.2, or in a narrative form containing the same information required in the PR-2 form.
Section 9792.9	Commenter states that notification letters need to be reduced. If the attending physician is the requester, then the utilization review organization should only have to send a letter to him/her. Sending letters to peripheral parties only increases the expense of the process.		Disagree. The notices are required by the statute.	None.
Section 9792.9(i) – was re-lettered 9792.9(j)	Commenter states that the regulations should mandate that if a non-certification or modification recommendation occurs to a requested intervention, the attending physician has the right to at least one telephonic appeal. Commenter argues that this will not abridge the right to a Labor Code section 4062 process, but prevent unnecessary utilization of this process in a number of situations that can be handled telephonically.		Agree. The written utilization review decision should disclose the hours of availability of either the physician reviewer or the medical director for the treating physician to discuss the decision. It is believed that a minimum of four (4) hours per week Pacific Standard Time is appropriate time to allow for the attending physician to discuss the utilization review decision with either the physician reviewer or the medical director.	Section 9792.9(j) has been amended to also require that the written decision shall also disclose the hours of availability of either the physician reviewer or the medical director for the treating physician to discuss the decision which shall be at a minimum four (4) hours per week Pacific Standard Time.
Section 9792.8	Commenter disagrees with the requirement that the utilization plan be made available to the physician, injured worker and the public Commenter states that attorneys are demanding these plans and it is just driving up		Disagree. The requirement that the criteria or guidelines used in the plan be available to the physician and injured worker if used as the basis for a decision to modify, delay, or deny	None.

	the cost of utilization review. Commenter believes that it should suffice that the plans are required to be filed with the DWC.		services, and to the public upon request is a requirement provided by the statute. (See, Labor Code section 4610, subdivisions (f)(4) and (f)(5).)	
Section 9792.7(b)(2)	Commenter states that the requirement that the peer reviewer must only review interventions that are within the scope of their practice is not practical.		Disagree. The requirement that no person, other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment is a requirement provided by the statute. (See, Labor Code section 4610(e).)	None.
Section 9792.7(b)(2)	Commenter requests that the term licensed physician should be defined as a physician who is licensed in any U.S. jurisdiction.		Agree. The evaluating physician should be licensed under any state and the statute does not limit this requirement to a California license. This is also consistent with the Medicare definition of physician services.	Section 9792.7(b)(2) has been modified to state that no person, other than a physician licensed under state law who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician's practice, may, except under specific circumstances, may delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury

Section 9792.9	Commenter states that employers and providers are concerned about infringing federal copyright laws by providing to the injured worker, injured worker's attorney or physician a copy of the criteria or guidelines used as the basis for a decision to modify, delay, or deny services.	**Lori Kamerer** **Kamerer & Company** January 21, 2005 Written comment	Disagree. The provision of the criteria is required by the statute. (Labor Code section 4610, subdivisions (f)(4) and (f)(5). See response to comment submitted by Julie K. Johnson, Assistant Vice-President of Medical and Disability Services, Liberty Mutual, dated December 8. 2004, above.	None.
Section 9792.8(a)(3)	Commenter objects to the requirement that a copy of criteria used in the UR determination should be provided to other parties. Commenter suggests that the criteria should be provided only upon request as this is extraordinarily burdensome to the UR process.	**Nancy Murphy,** Manager of Compliance **Broadspire** February 25, 2005 Written Comment	Disagree. The requirement that the criteria be provided to the pertinent parties is required by the statute. (Labor Code section 4610, subdivisions (f)(4) and (f)(5). See response to comment submitted by Julie K. Johnson, Assistant Vice-President of Medical and Disability Services, Liberty Mutual, dated December 8. 2004, above.	None.
Section 9792.6(k) – re-lettered 9792.6(n)	Commenter suggests that the regulations be amended to allow that requests for authorization be submitted in letter form in addition to the required forms.		Agree. It is reasonable to allow the physician to request authorization in a narrative form. For consistency purposes, however, the regulations will be amended to require that the request for authorization in narrative form must contain the same information required in the PR-2 form.	Section 9792.6(n) has been amended, in pertinent part, to state that both the written confirmation of an oral request and the written request must be set forth in Form DLSR 5021, section 14006, or in the Primary Treating Physician Progress Report DWC Form PR-2, section 9785.2, or in a narrative form containing the same information required in the PR-2 form.

General comment	Commenter believes that the mandatory notice language required in the regulations in connection with the UR determination letters is non-productive.		Disagree. The requirement that the criteria be provided to the pertinent parties is required by the statute. (Labor Code section 4610, subdivisions (f)(4) and (f)(5). See response to comment submitted by Julie K. Johnson, Assistant Vice-President of Medical and Disability Services, Liberty Mutual, dated December 8. 2004, above. Further, the notice language is intended to protect the rights of the parties.	None.
Section 9792.7(b)(2)	Commenter objects to the use of only physicians to modify, delay or deny requests for treatment authorization. Commenter urges the DWC to change the language in the regulations to allow like practitioners to oversee the authorization process where the provider requesting the authorization is not a physician (e.g. a physical therapist reviewer for a physical therapist request).	**Nancy Rothenberg,** Vice President **PTPN** February 9, 2005 Written Comment	Disagree. The requirement that only a licensed physician is authorized to delay, modify or deny a request for authorization of medical treatment is required by the statute. (Labor Code section 4610(e).)	None.
General comment	Commenter objects to the continued references to ACOEM. Guidelines throughout the regulations. Commenter states that the ACOEM Guidelines are flawed with regard to the handling of physical modalities such as physical therapy and occupational therapy.		Disagree. The ACOEM Guidelines have been incorporated as the interim medical guidelines in place pursuant to the statute. (Labor Code section 4610(c).) The issue of whether the ACOEM Guidelines properly address physical modalities or whether there should be separate guidelines form physical modalities will be addressed when the Administrative Director adopts regulations adopting the medical treatment utilization schedule pursuant to Labor Code section 5307.27.	None.

General comment	Commenter states that he understands the concern that insurers are denying appropriate medical care for procedures that are not covered by the ACOEM Guidelines. Commenter indicates that many payors are avoiding this problem by using ODG Treatment, which can cover virtually any procedure seen in workers' compensation because it is being updated monthly with the results of new studies and reports on treatment. Commenter further states that evidence base is "consistent with" the ACOEM Guidelines since it was the evidence base used for the 2nd edition of those guidelines, but of course now more current.	**Phil Denniston,** Work Loss Data Institute March 15, 2005 Written Comment	The comment does not address the substance of the regulation. In as much as the comment addresses the issue of whether the ACOEM Guidelines properly address all areas of appropriate medical care, that issue will be addressed when the Administrative Director adopts regulations adopting the medical treatment utilization schedule pursuant to Labor Code section 5307.27	None.
Section 9792.6(c) – re-lettered 9792.6(d)	Commenter states that the definition of "concurrent review" requires expansion and suggests that the definition be amended to state that concurrent review means utilization management conducted during workers hospital stay or course of treatment including outpatient procedures and services.	**Sharon L. Faggiano,** Employers Compensation Insurance Company March 11, 2005 Written Comment	Disagree. The definition of concurrent review as "utilization review conducted during an inpatient stay," is a definition carefully crafted to harmonize the requirements of a concurrent review with Labor Code section (g)(3)(B), which requires that in the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plans has been agreed upon by the physician that is appropriate for the medical needs of the employee. With regard to the outpatient treatment setting, it would be more appropriate to allow review of treatment using the ACOEM Guidelines which do not pertain to inpatient treatment.	None.

Section 9792.9	Commenter states that section 9792.9 contains inconsistent usage of the time frame pertaining to "5 working days" versus "5 days". Commenter recommends that the time frames be corrected to "five (5) working days."		Agree. Section 9792.9 contains clerical errors as addressed by the commenter. For consistency purposes the section will be amended to reflect the language of "5 working days," as opposed to "5 days."	Section 9792.9 has been amended throughout the body of the text to correct the clerical errors by substituting the language "5 days," with "5 working days."
Section 9792.9(b)(2)(A)	Commenter states that this section is contradictory to other sections in the regulations when it allows for the claims administrator to deny a request for authorization when reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the provider.	**Dale M. Clough,** Director of Workers' Compensation March 15, 2005 Written Comment	Agree. The statute provides that no person, other than a licensed physician may delay, modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury. Although the regulations intended the original provision to mean that the denial was based on lack of reasonable information, it is determined that this is not clear and may be confusing to the public.	Section 9792.9(b)(2)(A) has been amended to state that if the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the provider, a physician may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.
Section 9792.9(a)(1)	Commenter states that the time of the facsimile should be also required in 9792.9(a)(1) or otherwise it cannot be determined whether an emergency request was responded to within 72 hours as per 9792.9(d).	**David Biggs, Esq.** Law Office of John A. Mendoza March 18, 2005 Written Comment	Agree. Commenter is correct that the time of the facsimile should be also required in 9792.9(a)(1) to assist in the determination of whether an emergency request was responded to within 72 hours as per 9792.9(d).	9792.9(a)(1) has been amended to state, in relevant part, that the copy of the request for authorization received by a facsimile transmission shall bear a notation of the date, time and place of transmission and the facsimile telephone number to which the request was transmitted or be accompanied by an unsigned copy of the affidavit or certificate of

				transmission which shall contain the facsimile telephone number to which the request was transmitted.
Section 9792.9	Commenter states that the request for medical treatment should be sent to applicant's counsel at the same time and by the same means (facsimile or mail) it is sent to the claims administrator.		Disagree. This may be too burdensome on the physician as the physician may not know whether the injured worker is represented or may not know the injured worker's attorney or his or her address.	None.
Section 9792.9(b)(1)	Commenter requests that the request for medical authorization by the treating physician include the following additional information that alerts the applicant's counsel to the appropriate time periods that the claims administrator has to respond. This would include the following:			
	1. Whether the requests for medical authorization is prospective, concurrent, or retrospective.		Disagree. Labor Code section 4610 and these regulations set forth the necessary timelines. The treating physician may not know the various timelines for the different types of requests.	None.
	2. Whether the request for medical authorization is an emergency or non emergency request.		Agree. In order to insure proper processing of the request, the provider should indicate the need for an expedited review upon submission of the request.	Section 9792 has been amended to add new language that the provider must indicate the need for an expedited review upon submission of the request.
	3. If the request for medical authorization is an emergency request, a statement by the requesting physician that given the injured		Disagree. It is sufficient to require the physician to flag the request as emergency. The timelines are set	None.

	worker's condition the response should be in 72 hours or the specific time that is less than 72 hours. The far end of an emergency request is 72 hours but no one will know the minimum time that response is needed for the injured worker's condition if the requesting physician does not indicate this.		forth in the statute and regulations.	
	4. If the request for medical authorization is a non emergency request, a statement by the requesting physician that given the injured worker's condition the response should be in 5 working days or in less than 5 days and the number of days the response should be by. Section 9792.9 (b) (1) gives 5 days as the maximum days to respond but without the requesting physician indicating the time needed to respond given the injured worker's condition one has no way of knowing the minimum time a response is required given the injured worker's condition.		Disagree. Labor Code section 4610 and these regulations set forth the necessary timelines. The treating physician may not know the various timelines for the different types of requests.	None.
Section 9792.9 (b)(3)	The commenter states that section 9792.9 (b)(3) requires a response within 24 hours of the decision. This cannot be enforced unless there is a notation from the responder to the request for medical treatment indicating the date and time the decision was made to approve, modify, delay or deny a physician's request. The responder should be required to indicate the time and date they make the decision, in order to determine whether they responded within 24 hours.		Disagree. The regulations clearly set forth the necessary timelines for the claim administrator to issue the various responses.	None.
Section 9792.6(k) – re-lettered 9792.6(n)	The commenter states that section 9792.6 (k) (now section 9792.6(n)) "request for authorization" should be done on a form of its		Agree in part. Section 9792.6(k), now renumbered 9792.6(n) should be amended to reflect that a request for	Section 9792.6(n) "request for authorization" has been

	own and not just on a DLSR 5021, section 14006, or in the format required for Primary Treating Physician Progress Reports in subdivision (f) of section 9785. Commenter sets forth a list of items which should be included in the new form.		authorization may also be submitted in a narrative form containing the same information required in the PR-2 form. Disagree that the request should contain the list of items submitted by the commenter as the treatment is already contained in those forms, and it is not necessary to require the treating physician to duplicate the information.	modified to add new language the request may be also submitted in a narrative form containing the same information required in the PR-2 form.
Section 9792.6(j) – re-lettered 9792.6(m)	Commenter recommends that the term "prospective review" be defined to mean any utilization review, except for utilization review conducted during an inpatient stay, conducted prior to the delivery of the requested medical services.	**Brenda Ramirez** Medical & Rehabilitation Director California Workers' Compensation Institute March 22, 2005 Written Comment	Agree. This modification will clarify the regulations so that prospective and concurrent review will not overlap.	Section 9792.6(m) has been amended to state that "prospective review" means any utilization review, except for utilization review conducted during an inpatient stay, conducted prior to the delivery of the requested medical services.
Section 9792.6(k) – re-lettered 9792.6(n)	Commenter recommends that the term "request for authorization" be amended, at the last sentence, to reflect that the written confirmation of an oral request and the written request must be set forth "by the primary treating physician" in Form DLSR 5021, section 14006, or in the format required for Primary Treating Physician Progress Reports in subdivision (f) of section 9785.		Disagree. The requirement that the request for authorization originate solely from the primary treating physician is not consistent with the Labor Code. Under workers' compensation laws, other physicians, or secondary physicians, are allowed to see and treat the patient and can ask for treatment recommendations.	None.
Section 9792.7(b)(2)	Commenter notes that section 9792.7(b)(2) states that the physician reviewer is the only person who can delay, modify or deny a request for treatment authorization. Commenter further indicates that section		We Agree in part. The drafted regulations contained an inconsistency. Pursuant to the statute only the physician reviewer may	Section 9792.9(b)(2)(A) has been amended state that if the reasonable information requested by

	9792.9(b)(2)(A), on the other hand, allows a claims administrator to deny a request for treatment authorization for lack of appropriate information after the information has been requested. Commenter recommends that section 9792.7(b)(2) be amended to reference section 9792.9(b)(2)(A) to reflect that the claims administrator may deny a request for treatment authorization for lack of information previously requested.		deny a request for treatment authorization. Therefore, section 9792.9(b)(2)(A) has been amended to state that the physician reviewer is responsible to deny the request for treatment authorization for lack of information, not the claims administrator.	the claims administrator is not received within 14 days of the date of the original written request by the requesting physician, a physician reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.
Sections 9792.8-9792.10	Commenter states that The claims administrator should only be required to send written notice of the decision to modify, delay or deny the request for authorization, in addition to all the parties listed in the regulations, to a provider of goods identified in the request for authorization.		Agree. Commenter is correct that the claims administrator should only be required to send written notice to a provider of goods identified in the request for authorization. This will avoid the problem with failure to serve unknown parties. The same reasoning applies to the provider of services.	Sections 9792.8(a)(3), 9792.8(3)(B), 9792.9(c), 9792.9(g)(2), 9792.9(j), 9792.9(k), 9792.10(b)(1) have been amended, in relevant part, to state that the notice required the regulations shall be served, in addition to all the parties listed in the regulations, to a provider of goods or services identified in the request for authorization..
Section 9792.9(a)(1)	Commenter requests that section 9792(a)(1) be amended to clarify that a written request for authorization may be deemed to have been received by the claims administrator by facsimile on the date the request was received if the receiving facsimile electronically date stamps the transmission, or the date the request was transmitted.		Agree in part. Commenter is correct that "date of receipt" refers to the time when a document is actually received. The regulations will be modified to reflect that the written request for authorization shall be deemed to have been received by the claims administrator by facsimile on the date the request was received if	Section 9792.9(a)(1) has been modified in relevant part to state that for purposes of this section, the written request for authorization shall be deemed to have been received by the claims administrator by facsimile

			the receiving facsimile electronically date stamps the transmission, or the date the request was transmitted.	on the date the request was received if the receiving facsimile electronically date stamps the transmission, or the date the request was transmitted.
Section 9792.9(a)(1)	Commenter further states that while utilization review access may be provided until 5:30 PM, requests received after 5:00 PM cannot reasonably expect action until the following work day. Commenter requests that requests received after 5:00 PM are deemed received on the following business day.		We do not agree with the statement that the facsimile request for authorization received after 5:00 PM should be deemed to have been received on the following business days. The definition of a business day in the regulations is controlled by the definition set forth in Labor Code section 4600.4 and in section 9 of the Civil Code.	None.
Section 9792.9(f)(2) – re-lettered 9792.9(g)(2)	Commenter states that the portion of this section regarding the timeframe extension notice identifying the expert reviewer to be consulted should be amended to "the type of expert reviewer to be consulted" because it is unlikely that the expert reviewer has been consulted or identified at the time of this notice of timeframe extension.		Agree. It is reasonable for the claims administrator to extend the timeframe to consult an expert reviewer and not know the specific person it will be consulting. The requirement that the notice include the type of expert reviewer to be consulted as opposed to actually identifying the expert reviewer is reasonable.	Section 9792.9(g)(2) has been modified, in relevant part, to state that if subdivisions (A), (B) or (C) above apply, the claims administrator shall immediately notify the requesting physician, the provider of goods or services identified in the request for authorization, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the claims administrator cannot make a decision

				within the required timeframe, and specify the information requested but not received, the additional examinations or tests required, or the specialty of expert physician reviewer to be consulted.
Section 9792.9(i)(8) – re-lettered 9792.9(j)(8)	Commenter states that the mandatory language contained in this section should be amended to allow the claims administrator to either provide the injured employee with a single number of the district information and assistance office or a listing of all the offices. Commenter suggests that a listing of all the offices may be helpful to employees who travel on the job.		Agree. It is reasonable for the claims administrator to provide the injured worker with either a single number of the district information and assistance office or a listing of all the offices.	Section 9792.9(j)(8) has been modified, in relevant part, to include the following mandatory language: “Either "If you want further information, you may contact the local state Information and Assistance office by calling [enter district I & A office telephone number closest to the injured worker] or you may receive recorded information by calling 1-800-736-7401. or “If you want further information, you may contact the local state Information and

				Assistance office closest to you. Please see attached listing (attach a listing of I&A offices and telephone numbers) or you may receive recorded information by calling 1-800-736-7401."
Section 9792.6(e) – re-lettered 9792.6(d)	Commenter objects to the definition of "concurrent review," stating that there is no authority in the statute for restricting concurrent review to apply only during an inpatient stay.	**J. David Schwartz** President, California Applicants' Attorneys Association March 21, 2005 Written Comment	Disagree. Although commenter is correct that the statute does not provide for a restriction to concurrent review to an inpatient setting, it was necessary to harmonize this provision with the statutory requirement that "in the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee." It was the consensus that in an inpatient setting, the employee's physician would be more amenable to agree on a care plan with the claims administrator than in an outpatient setting. In order to avoid stagnation in agreements between the physicians and the claims administrators on health care plans in outpatient settings, it was determined that concurrent review should be restricted only to inpatient settings, and that prospective or retrospective review should apply to outpatient settings.	None.

Section 9792.7(a)(4)	Commenter states that this section should be amended to confirm that the "description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan" includes a complete list of all physicians who will review requests for treatment under that UR program. Commenter further states that the section should require that the information provided on each UR physician describe the professional status of the physician, describing whether the physician is in active practice, is in teaching position, is retired, or other status. Commenter also states that the section should require that the information should disclose the estimated percentage of income received by the physician for conducting UR reviews.		Disagree. The requirements suggested by the commenter are beyond the scope of the statute. The statute requires that the physician reviewer be a physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician reviewer's practice (Labor Code, section 4610(e).	None.
Sections 9792.7(b)(2), 9792.9(f)	Commenter states that these sections should be modified to require that the UR physician to have the same Board specialty of the requesting physician, and if the UR physician is different from the requesting physician, the UR physician should be required to submit a written explanation describing the experience or education of the UR physician in order to demonstrate that this physician is competent to evaluate the requested treatment. Commenter further suggests that the "scope of practice" be defined to require that the physician have a certain number of years of experience, or that the physician devote a certain percentage of his or her practice to the type of treatment being requested.		Disagree. See response above.	None.
Section 9792.7(b)(3)	Commenter expresses the concerns that the language of this section is too inexact and		Disagree. This section is clear that a non-physician reviewer may initially	None.

	would effectively allow a nurse to deny treatment. Commenter recommends that the language of the section be modified to require that any determination that a treatment request should be modified, delayed or denied can only be made by a competent physician.		apply specified criteria to requests for authorization for medical services and to approve requests for authorization of medical services to expedite the provision of these services. In performing these duties, the non-physician reviewer can discuss the applicable criteria with the requesting physician. If the requesting physician is made aware that the treatment for which authorization is sought is inconsistent with the criteria, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization which the non-physician reviewer may approve. If not, the request if forwarded to the physician reviewer for review. Further, the section is clear that a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision but in no event the time involved may exceed the time limitations imposed in section 9792.9 subdivisions (b)(1), (b)(2) or (c), and any time beyond the time specified in these paragraphs is subject to the provisions of subdivision (f)(1)(A) through (f)(1)(C) of section 9792.9. Also, Section 9792.9(b)(2) to makes it clear than only a physician reviewer may deny a request for authorization.	

Sections 9792.7(b)(3), 9792.9(f)(1) – re-lettered 9792.9(g)(1)	Commenter objects to the extension of the time frames referenced in the last sentence of §9792.7(b)(3) and outlined in proposed §9792.9(f)(1)(A) through (f)(1)(C). Commenter states that the DWC has no authority to extend the time frames for utilization review beyond those set in statute.		Disagree. The extension of the time frames referenced in the last sentence of §9792.7(b)(3) and outlined in proposed §9792.9(f)(1)(A) through (f)(1)(C) are required by Labor Code section 4610(g)(5).	None.
Section 9792.8(a)(1)	Commenter states that in a separate letter dealing with the medical treatment utilization schedule regulations proposed by DWC, he recommends that steps be taken to reduce the problems cited in the recent RAND report on treatment guidelines. Commenter further states that the ACOEM Practice Guidelines are being misapplied, and this should be defined as a violation of the UR process.		Disagree. The comment is outside the scope of these regulations. Inasmuch as commenter addresses issues relevant to the medical treatment utilization schedule regulations pursuant to Labor Code section 5307.27, his comments will be taken into consideration in connection with those regulations. Insofar as the commenter is addressing issues relating to penalties for UR violations, that issue will be addressed separately in the UR penalty regulations which are in the process of being drafted.	None.
Section 9792.9(f) – re-lettered 9792.9(g)	Commenter objects to the timeframe extensions set forth in section 9792.9(g) not supported by the statutory language of Labor Code in §4610.		Disagree. The extension of the time frames outlined in proposed §9792.9(f)(1)(A) through (f)(1)(C) are required by Labor Code section 4610(g)(5).	None.
Section 9792.9(f) – re-lettered 9792.9(g)	Commenter requests that this section be amended to require that the appropriate fax number be provided to each treating physician within 24 hours of receipt by the claim adjuster of notification of treating physician status. Commenter states that this should include any physician selected by the worker		Disagree. To impose the suggested requirements would create a great burden on the claims administrator. Further, the requirements set forth by the commenter are not required by the statute, and in fact are beyond the scope of the statute.	None.

	as well as the physician selected by the worker as well as the physician selected by the employer to be the initial treating physician under a medical provider network.			
Section 9792.9(i)(9) – re-lettered 9792.9(j)(9)	Commenter objects to this section requiring that any notice must include details about the "internal utilization review appeals process, if any". Commenter opposes the use of another appeal process. Commenter further indicates that if the paragraph is not deleted, the mandatory warning should be strengthened. Specifically, commenter suggests that this warning should be in 15 point type, or larger, and should be placed in a highlighted box in a prominent position in this notice.		Disagree. Section 9792.9(j) is clear that the internal utilization appeals process is on a voluntary basis. The section is further clear that the internal utilization appeals process is not intended to supercede the appeals process set forth by the statute.	None.
Section 9792.11	Commenter states that the failure to provide any rules for establishing and collecting penalties pursuant to Labor Code §4610(i) is a major flaw in the regulations.		Disagree. Issues relating to penalties for UR violations will be addressed separately in the UR penalty regulations which are in the process of being drafted.	None.
General comment	Commenter states that she appreciates the Division's recognition that the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines are lacking in some areas, as reflected by the language in the proposed regulations referencing conditions or injuries not covered by the ACOEM Practice Guidelines. Commenter requests amendment of this language to also include treatments not covered by the ACOEM Practice Guidelines	**Kathleen S. Creason** Executive Director, Osteopathic Physicians & Surgeons of California March 21, 2005 Written & Oral Comment	Comment goes beyond scope of regulations. Insofar as the comment addresses the issue of whether the ACOEM Guidelines properly address all areas of appropriate medical care, that issue will be addressed when the Administrative Director adopts regulations adopting the medical treatment utilization schedule pursuant to Labor Code section 5307.27	None.
Section 9792.6(d) - now re-lettered 9792.6(e)	Petitioner states that he frequently finds that physicians that refer patients to physical therapists and rely on those therapists to develop a course of treatment, or plan of care,	**Bill Hutchins** California Physical Therapy Association March 22, 2005	Agree in part. In the instances where a physician is not specific in the treatment as authorized, the specifics of the treatment plan would be filled	Section 9792.6(e) has been amended to state that "course of treatment" means the course of

	for the injured worker but the current regulations require that the course of care be authorized pursuant to the submission of a 5021 or PR-2. In addition, commenter states that problems occur when a carrier requests a copy of the First Report or PR-2 from the physical therapy clinic. This form is filled out only by the physician.	Written Comment	in by the physical therapist, but in these instances the claims administrator have already authorized the treatment. The physical therapist is not stepping into the role of the treating physician. However, in order to facilitate communication, the regulations should be amended to specify that the request, as submitted by the treating physician, may also be in a narrative form containing the same information required in the PR-2 form.	medical treatment set forth in the treatment plan contained in the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021 or in the "Primary Treating Physician's Progress Report," DWC Form PR-2, section 9785.2, or in a narrative form containing the same information required in the PR-2 form.
Section 9792.6(h) – now re-lettered 9792.6(j)	Commenter states that the definition of "health care provider" should be amended to state that a "health care provider" means a licensed provider of medical services as licensed by the State of California, as well as related services or goods, including but not limited to an individual licensed provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616."		Disagree. It is unnecessary to add the license requirement, as it is not the jurisdiction of DWC to determine license status.	None.
Section 9792.6(k) – now re-lettered 9792.6(n)	Commenter requests that the term "request for authorization" be amended to also refer "physical medicine and rehabilitation treatment" in addition to "a specific course of proposed medical treatment."		Disagree. Physical medicine and rehabilitation treatment is part of the specific course of medical treatment. There is no need to separate them.	None.
General comment	Commenter requests that the term "physical therapist" be inserted in addition to the term "physician" throughout the regulations (i.e.,		Disagree. Physical therapists are not authorized under the Labor Code to be treaters. Labor Code section	None.

	"… treatment recommendation by physician and physical therapist").		3209.3 lists the professions authorized to treat under workers' compensation as physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners.	
Section 9792.6(o) – now re-lettered 9792.6(r) Section 9792.9(a)(1)	Commenter requests that the definition of and reference to the term "written" be amended to include "any form of electronic means to include but not limited to e-mail, web portal," in addition to facsimile and communications in paper form.	**Eric Leinwohl,** Managing Director, CID Management March 22, 2005 Written comment	Disagree. The earlier drafts of these regulations contained the proposed language. However, DWC received many comments from the public requesting that the regulations require "secure means of electronic communication" language included throughout the regulation when referencing e-mail communication. In researching the term "secure electronic communications" it was determined that under The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 (42 U.S.C. §1301 et seq.) and applicable federal regulations (45 C.F.R. §160.101 et seq.), there is no specific definition for that term. However, the HIPAA federal regulations contain an entire subpart entitled "Security Standards for the Protection of Electronic Protected Health Information" (45 C.F.R. §§164.302-164.318), setting forth the applicable standards, implementation specifications, and requirements with respect to electronic protected health	None.

			information. Generally, these regulations set forth standards for administrative safeguards, physical safeguards, technical safeguards, organizational requirements, policies and procedures and documentation requirements. The regulations further set forth compliance dates for the initial implementation of the security standards, and contain a security standards matrix as an appendix. It was noted that HIPAA is not applicable to workers' compensation. (42 USC §1320d-7(a)(2).) Further, it was determined that incorporation of HIPAA standards into the utilization review regulations could result in the adoption of very technical requirements which might not be appropriate for the utilization review regulations. (See, 45 CFR 164.302-164.318.) Further, comments were received from the California Medical Association (CMA), stating that HIPAA security regulations would become effective "April 2005" and under the UR regulations, as drafted, "common e-mail methods [would] clearly not be considered secure and any provider transmitting protected health information ("PHI") by non secure means [would] be in violation." CMA further stated that "[w]hile HIPAA clearly exempts	

			workers' compensation carriers, it does not exempt providers," and that CMA "[was] concerned that providing for e-mail exchange of PHI while not addressing reasonable security measures to protect the privacy of patients[, the regulations] [could] lure providers into thinking such communications are appropriate." CMA requested that this issue "be carefully considered and either the provisions for e-mail be removed from [the regulations] or [they] be modified to stress security of communications and such requirements be spelled out." As previously indicated, HIPAA is not applicable to workers' compensation, and incorporation of HIPAA standards into the utilization review regulations may result in the adoption of very technical requirements which might not be appropriate for the utilization review regulations. However, DWC was persuaded that CMA was correct that if the UR regulations were not consistent with HIPAA security standards, the providers would be negatively impacted by this inconsistency which could result in legal exposure. Thus, the provision that the request for authorization may be submitted by e-mail was removed from the	

			regulations.	
Section 9792.7(a)	Commenter suggests deletion of letter "s" in the term "claims administrator."		Disagree. The term "claims administrator" is commonly used throughout our regulations.	
Section 9792.7	Commenter suggests that the Administrative Director review the utilization review plan for content to prevent non-professionals from making clinical decisions that result in injury to the worker.		Disagree. Not required by the statute. However, inasmuch as this comment relates to violations of the regulations, issues relating to penalties for UR violations will be addressed separately in the UR penalty regulations which are in the process of being drafted.	None.
Section 9792.7(d)(1)	Commenter makes reference to this section which states, in relevant part that "if a member of the public requests a hard copy of the utilization review plan, the claims administrator may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $0.25 per page plus actual postage costs." Commenter then states that it would be interesting to establish a pay for performance as an incentive. Commenter could appreciate this initiative in a more controlled environment such as the MPN, and upon success, it could be introduced under different circumstances.		Disagree. Comment goes beyond the scope of the regulations.	None.
Section 9792.9(c)	Commenter suggests that the following sentence be inserted at the end of this section in reference to emergency health care services: "Said documentation for emergency services shall be available for review by the claims administrator."		Agree. It is reasonable to require that documentation for emergency health care services be made available to the claims administrator for review upon request.	Section 9792.9(c) has been amended to add a new sentence at the end of the section stating, "documentation for emergency health care

				services shall be made available to the claims administrator for review upon request.
Section 9792.11	Commenter requests that enforcement of this section should be enacted immediately and should include the claims administrator, employer as well as the UR vendor. Commenter further states that penalties to the provider should be should also be enacted if the and when their actions lead inappropriate management and/or injury to the employee/patient.		Disagree. The section relating to UR penalties has been deleted from these regulations. Issues relating to penalties for UR violations will be addressed separately in the UR penalty regulations which are in the process of being drafted.	None.
General comment	Commenter states that some claims administrators, and their UR vendors, are requesting copies of the physician's first report and/or PR-2 forms from physical therapist prior to authorizing care. Commenter states that while this is clearly not the responsibility of the physical therapy provider, many are forced to track down the requested physician reports merely to expedite the authorization process.	**Stuart Katzman, PT** Chair, California Physical Therapy Assoc., Govt. Affairs Comm. Owner, Evergreen Physical Therapy, San Jose, Redwood City Physical Therapy, Redwood City March 21, 2005 Written & Oral comment	Disagree. It is necessary for the claims administrator to request proper documentation of the injured employee's condition prior to making a decision of the necessity of the recommended physical therapy.	None.
General comment	Commenter states that there are significant delays in responding to requests for authorization to commence physical therapy treatment. Commenter further states that claims administrators are demanding submission of a "written authorization letter" as a requirement for claims payment, yet, many have not made it a common practice to follow verbal authorization with a subsequent confirmation in writing.		Disagree. Issues relating to penalties for UR violations will be addressed separately in the UR penalty regulations which are in the process of being drafted.	None.

General comment	Commenter states that the AAICP is pleased to support the Final Proposed Regulations and recommends that they be adopted in their current form. The commenter further states that the AAICP praises DWC for clarifying the purpose and intent of the enabling Labor Code sections regarding the timeframe, procedures, and notice content of the utilization review requirements. In particular, commenter states that the AAICP wishes to highlight the following points: Commenter states that its organization applauds the Department for setting forth a regulatory proposal that is consistent with the intent and plain wording of Labor Code Section 4610 which requires employers to establish and maintain a utilization review process. Commenter further states that section 9792.9 sets forth specific timing and procedural requirements of the utilization review process to ensure timely delivery of adequate and necessary medical care through an evidenced-based approach that provides medical treatment in accordance with contemporary medical standards. Commenter also states that section 9792.6 sets forth the definitions of "concurrent review" to mean a utilization review conducted during an inpatient stay and "prospective review" to mean a utilization review conducted prior to the delivery of requested medical services.	**Darrell Brown** Vice President Sedgwick Insurance American Association of Independent Claims Professionals March 21, 2005 Written & Oral comment	Agree.	None.

	These definitions are essential to the interpretation of proper utilization review standards under Section 9792.9. Commenter further states that the AAICP applauds the express application of the American College of Occupational and Environmental Medicine ("ACOEM") Practice Guidelines to the utilization review process and for permitting the standard for circumvention of these guidelines in certain circumstances. The use of the ACOEM Practice Guidelines legitimizes the utilization process and reduces administrative costs.			
General comment	Commenter states that the regulations should set standards for the Utilization Review Program that focus on the goals of eliminating outlier treatment except when necessary for the health of the injured worker. Commenter states that most UR programs identify triggering events or recommendations that qualify for a review, such as a surgery, request for hospitalization, or physical therapy visits beyond a certain number. It is not supposed to be a system whereby every prescription, diagnostic test or physical therapy visit is reviewed. To do so, as some insurers are doing, is to insure that the process bogs down under its own weight in which case we will be spending more money denying treatment that if it had been authorized in the first place.	**Peggy Sugarman** Executive Director Voters Injured at Work.org March 22, 2005 Written & Oral comment	Disagree. The regulations, as written, do not require that every claim go through UR process. The regulations are drafted pursuant to the statute, and set forth the requirements of the UR process as delineated by the statute.	None.
General comment	Commenter states that the utilization reviewers should be a foremost authority on the guidelines. Commenter further states that physician recommendations for guideline treatment or diagnostic tests should be		Disagree. The statute, and the regulations pursuant to the statute, set forth the qualifications of the physician reviewer. Any further requirements would be beyond the	None.

	routinely approved if consistent with the guidelines, regardless of whether the physician specifies the exact page of the ACOEM guidelines that supports his or her recommendation.		scope of the statute.	
General comment	Commenter states that the regulations lack oversight of UR process. Commenter states that the UR regulations should require descriptions of the UR plans' standards and should have a feedback mechanism to insure that the plan is workable or acceptable.		Disagree. These requirements are beyond the scope of the statute.	None.
Section 9792.11	Commenter states that it would be a good idea to set up an audit hotline where injured workers can report delays of treatment that exceed the statutory time frame.		Disagree. Issues relating to penalties for UR violations will be addressed separately in the UR penalty regulations which are in the process of being drafted.	None.
Section 9792.8(a)(4)	Commenter states that the regulations should allow the practicing physician to utilize his or her immediate medical judgment in the ordering of diagnostic tests or services based on the illness or injury presented to the physician. Commenter further states that x-rays and laboratory tests are diagnostic tools to assess the patient and direct further care and/or treatment, and should not be part of the utilization review process.	**Michael D. Hadley, M.D.** Lead Medical Director Occupational Medicine Department Health Care Partners Medical Group March 22, 2005 Written & Oral comment	Agree in part. A new section 9792.8(a)(4) has been added to the UR regulations to clarify that nothing in section 9792.8 regarding the utilization review standards and medically-based criteria precludes authorization of medical treatment not included in the specific criteria disclosed under section 9792.7(a)(3). However, we disagree with the comment that x-rays and laboratory tests should not be part of the utilization review process. These procedures have been traditionally considered part of the utilization review process.	New section 9792.8(a)(4) has been added to the regulations, stating that "[n]othing in this section precludes authorization of medical treatment not included in the specific criteria disclosed under section 9792.7(a)(3)."
General comment	Commenter states that the regulations should mandate greater flexibility in the ACOEM		Disagree. The comment is outside the scope of the statute. Issues relating to	None.

	guidelines to address acuity of the illness or injury; specific to age of the injured worker; the medical conditions and degree of disability impact of non-job related pre-existing conditions.		guidelines addressing areas not addressed by ACOEM will be visited in the regulations concerning the medical treatment utilization guidelines schedule which are in the process of being drafted.	
General comment	Commenter states that the regulations should allow for other evidence based medical guidelines to determine appropriateness of care and treatment of the injured worker. Commenter further states that this may include American College of Surgeons; American Osteopathic Association; American College of Orthopedic Surgeons and other clinical board specialties.		Disagree. See response above.	None.
General comment	Commenter states that the regulations should redefine the provisions for utilization review to assure non-medical reviewers are educated to perform case management using ACOEM guidelines if there are unclear case issues, they are directed to physician supervision.		Disagree. Comment is outside the scope of the statute.	None.
General comment	Commenter states that the regulations should allow for the provision in the legislation to augment the utilization review standards to reward physicians with a Pay for Performance Program if they support a "back to work programs; light duty assignments; & reduce the down time of injured workers".		Disagree. The comment is outside of the scope of the statute.	None.
General comment	Commenter states that the regulations should expedite the decision to update the OMFS by the end of 2005 to assure quality medical providers can continue to support treatment to injured workers. Commenter states that		Disagree. The comment is outside the scope of the statute.	None.

	currently a 15-25% reduction in payments is creating a negative impact on the ability of our offices to continue serving the Occupational Medicine.			
General comment	We agree that ACOEM Guidelines serve well as the base for UR standards and that other evidence-based medical treatment guidelines recognized by the national medical community and are scientifically based should be used for conditions not covered by ACOEM Guidelines.	**Fred Fung, M.D.** Sharp HealthCare/Sharp Rees-Stealy Medical Group March 22, 2005 Written & Oral comment	Disagree. The comment is outside the scope of the statute. Issues relating to guidelines addressing areas not addressed by ACOEM will be visited in the regulations concerning the medical treatment utilization guidelines schedule which are in the process of being drafted.	None.
General comment	Commenter states that the UR regulations should contain a provision indicating that ACOEM Guidelines may also be applicable to chronic conditions resulted from the same acute injury		Disagree. The comment is outside the scope of the statute. Issues relating to areas not addressed by ACOEM will be visited in the regulations concerning the medical treatment utilization guidelines schedule which are in the process of being drafted.	None.
General comment	Commenter states that the UR regulations should contain a provision for basic training on the use of ACOEM Practice Guidelines for non-physician reviewer such as claims administrator and adjuster.		Disagree. The comment is outside to the scope of the statute. Issues relating to penalties for UR violations will be addressed separately in the UR penalty regulations which are in the process of being drafted.	None.
General comment	Commenter states that the preface of ACOEM Guidelines, 2nd edition "provides information and guidance on generally accepted elements of quality care in occupational and environmental medicine." Commenter further states that a training manual on ACOEM Guidelines for non physicians is now being developed by Western Occupational and		Disagree. The comment is outside the scope of the statute. Issues evidence-based medicine will be visited in the regulations concerning the medical treatment utilization guidelines schedule which are in the process of being drafted. Training of insurance claims administrators and personnel	None.

	Environmental Medical Association (part of ACOEM). Commenter believes that this along with appropriate training courses approved by DWC may serve to educate claims administrators and personnel who have limited knowledge in Evidence-based medicine and the understanding of the applications and limitations of medical practice guidelines in general. Commenter believes that this may streamline UR processes and facilitate cost effective patient care instead of delaying decisions on a medical service request. Commenter further states that when a request clearly falls within ACOEM Guidelines, service should be approved without delay to ensure injured workers receive appropriate treatment and thus able to return to work sooner than later. Commenter states that he believes that a better understanding of the ACOEM Guidelines by all parties involved will result in improved outcomes in terms of cost effective claims management and quality of care provided to injured workers in a timely manner.		is outside the scope of these regulations.	
Section 9792.21 Section 9792.8	Commenter suggests section 9792.21 of the Medical Treatment Utilization Schedule be amended to state that "treatment may not be denied on the basis that the specific treatment for the specific indication in question is not addressed by the ACOEM Practice Guidelines. Commenter recommends that section 9792.8(a)(2) be amended to state that treatment may not be denied on the basis that the specific treatment for the specific indication in question is not addressed by the	**N. William Fehrenbach** Director, State Government Affairs Medtronic March 21, 2005 Oral and written comment	Disagree. The comment is outside the scope of these regulations. The comment will be taken into consideration in connection with the Medical Treatment Utilization Schedule regulations. Agree. Section 9792.8(a)(2) has been amended to state that treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Guidelines. Disagree with	None. Section 8792.8(a)(2) has been amended to state: "For all conditions or injuries not addressed by the ACOEM Practice

	ACOEM Practice Guidelines.		the comment that the same language should be inserted in Section 8792.21 of the Medical Treatment Utilization Schedule.	Guidelines or by the official utilization schedule after adoption pursuant to Labor Code section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based. Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines."
Section 9792.8(a)(2)	Commenter recommends that the word "covered" be replaced with the word "addressed" in section 9792.8 to clarify that some treatments may simply not be mentioned in ACOEM that are in fact covered by carriers.		Agree. The word "covered" should be replaced with the word "addressed" in section 9792.8 to clarify that there are treatments not mentioned in ACOEM but it does not necessarily mean the treatment is not covered by certain insurance policies.	Section 9792.8(a)(2) has been amended to substitute the word "covered" with the word "addressed."
Section 9792.9(b)(2)(A)	Commenter indicates that the regulations are not clear as to what timeframes and procedures govern the event wherein the claims administrator requests reasonable information and the information is not received within 14 days, and the claims administrator then denies the request stating that reconsideration will be granted upon receipt of the information.		Disagree. Sections 9792.9(f)(1)(A) and 9792.9(f)(3) and (f)(4) (now re-lettered 9792.9(g)(1)(A) and 9792.9(g)(3) and (g)(4)) are clear that upon receipt of the requested information, the claims administrator must make the decision to approve, modify, or deny the request within 5 working days of receipt of the	None.

			information for prospective or concurrent review and within 30 working days for retrospective review.	
Section 9792.9(f) (now re-lettered §9792.9(g)	Commenter states that the broad exemptions delineated in (f)(1)(A)-(C) result in decisions being delayed literally for 6-12 months or longer. Commenter suggests that address this problems, subdivision (f)(1) should contain a limitation of no more than 4 months:		Disagree. DWC is aware that at the present time, there are delays with respect to the extended timeframes pursuant to subdivision (g)(1)(A)(B), and (C). Unfortunately, an implementation of an overall cap under the extended circumstances is beyond the scope of the statute. The statute does not provide for a determined timeline in this regard, and this is logical because it is difficult if not impractical to put time limitations on medical tests, medical examinations or specialized consultations and medical review by expert physician. DWC will, however, address this issue in the UR penalty regulations which are in the process of being drafted, and will be filed with OAL on an emergency basis. Further, the injured worker has the option if the delay is unreasonable to request for an expedited hearing under Labor Code section 5502(b) and California Code of Regulations, title 8, section 10136, or file a complaint to the DWC-Audit Unit.	None.
Section 9792.11	Commenter states that he is aware of the permissive audit powers and penalty section provided to the administrator under 9792.11,		Disagree. The issue of UR penalties will be addressed in the UR penalty regulations which are in the process	None.

	but opines that a reasonable level of automatic fines/penalties is a much more administratively simple and effective way to ensure that regulated entities act in good faith. Commenter requests adoption of automatic fines/penalties within the UR rule.		of being drafted, and will be filed with OAL on an emergency basis.	
Section 9792.6(c) (Now re-lettered §9792.6(d))	Commenter states that the proposed definition of "concurrent review" in 8 CCR § 9792.6(c) limits concurrent review to those situations in which the injured worker is in an inpatient environment. Commenter states that this is not supported either by the provisions of Labor Code § 4610 or by acceptable medical utilization review practices. Commenter recommends that if the Division wishes to amend this definition, it should include that concurrent review may also take place in an ongoing outpatient course of treatment.	**Mark E. Webb**, Assistant General Counsel American International Companies March 22, 2005 Written comment	Disagree. The definition of concurrent review as "utilization review conducted during an inpatient stay," is a definition carefully crafted to harmonize the requirements of a concurrent review with Labor Code section (g)(3)(B), which requires that in the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. With regard to the outpatient treatment setting, it would be more appropriate to allow review of treatment using the ACOEM Guidelines which do not pertain to inpatient treatment.	None.
Section 9792.6(g) (Now §9792.6(h)	Commenter states the proposed creation of and definition of "expert reviewer" in 8 CCR § 9792.6(g) is not supported by the plain language of Labor Code § 4610. Commenter believes that this definition is part of an overall regulatory concept in these proposed regulations allowing modification or denials of treatment by other than licensed physicians. Commenter further states that the entirety of this part of the proposal lacks authority as that		Agree in part. Labor Code section 4610(g)(5) provides, in pertinent part, that if "the employer, insurer, or other entity cannot make a decision within the timeframes … because … the employer requires consultation by an expert reviewer … the employer shall immediately notify the physician and the employee in writing …." Thus, the statute	Section 9792.6(h) has been amended for clarification purposes. The section now states: "Expert physician reviewer" means physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists,

	term is used in Government Code § 11349(b), and lack clarity and consistency under Government Code §§ 11349(c) and (d).		provides for an extension of the timeframes in situations where the employer requires a consultation with an expert reviewer. During the pre-rulemaking process many members of the public requested that the term "expert reviewer" be defined. However, we agree with the commenter that the definition should be clarified to reflect that the expert reviewer definition excludes non-physicians reviewers. Thus, the definition has been amended for clarification purposes to state: "Expert physician reviewer" means physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by any U.S. Jurisdiction, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the licensure and scope of the physician's practice, who has been consulted by the physician reviewer or utilization review medical director to provide specialized review of medical information.	optometrists, dentists, podiatrists, and chiropractic practitioners licensed by any U.S. Jurisdiction, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the licensure and scope of the physician's practice, who has been consulted by the physician reviewer or utilization review medical director to provide specialized review of medical information.
Section 9792.7(b)	Commenter states that in one section of the proposed regulations, the regulations correctly recites the requirement that the review and decision to deny, delay, or modify requests for authorization can only be made by physicians competent to evaluate the specific clinical		Disagree. It is unclear what the commenter is trying to communicate. Utilization review business practices allow for the request for medical treatment to go first to the claims examiner, the claims examiner	None.

	issues involved and where the services are within the scope of the physician's practice. [8 CCR § 9792.9(e).] However, commenter states that in another section, the Division states that there are "exceptions" to this rule when discussing the applicability of the UR standards. [8 CCR § 9792.7(b)(2)] This latter proposed regulation is facially at odds with subdivision (e) of Labor Code § 4610, and is inconsistent with the discussion of "exceptions" in the very next paragraph. [8 CCR § 9792.7(b)(3)]		allows the non-physician review to evaluate the request, if the request is accepted, there is no need to involve a physician reviewer. If there is need for further information to clarify the request, the non-physician reviewer may request such information within the proper timeframes to complete the record for the physician reviewer. Thereafter, the request is moved on to the physician reviewer to issue a decision on the request within the timeframes set forth in the statute. There is no internal inconsistency in the regulations as apparently alleged by the commenter.	
Section 9792.7	Commenter states that proposed 8 CCR § 9792.7(b)(3) attempts to codify when a "non-physician reviewer" may discuss with a requesting physician the nature and scope of the treatment for which authorization is being sought. Commenter notes that the term "non-physician reviewer" is not defined and does not appear in 8 CCR § 9792.9 relating to timeframes. Commenter further notes that this latter section refers only to a claims administrator and "physician reviewer". Commenter further notes that a "physician reviewer" is not defined either, but must be someone other than a "non-physician reviewer" or an "expert reviewer". Commenter also states that while cited in 8 CCR § 9792.7(b)(2) as the "exception" to the absolute prohibition against non-physicians denying, delaying, or modifying requests for information, 8 CCR § 9792.7(b)(3) in fact		Agree in part. It is difficult to understand what the commenter is trying to communicate. However, there are two modifications which have been made to the regulations for clarification purposes. First, pursuant to the comment submitted by Brenda Ramirez from CWCI, dated March 22, 2005, section 9792.9(b)(2)(A) has been amended state that if the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the requesting physician, a physician reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested. This modification resolves the question of	Section 9792.9(b)(2)(A) has been amended state that if the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the requesting physician, a physician reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested. Further, a new subdivision has been added to the regulations,

	does not actually empower the non-physician reviewer to *deny* the request but rather only gives the non-physician reviewer the ability to say, "You'd better deal with me on this or I'll recommend a denial to someone who really can deny it."		whether or not a non-physician reviewer may deny a request for medical treatment. The regulations are now clear that only a physician may deny, delay or modify a request for medical treatment. (See response to Ms. Ramirez's comment above.) Second, a definition for the term physician reviewer has been added to the regulations for clarification purposes to state that a "physician reviewer" means physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by any U.S. Jurisdiction, competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician's practice. Because the terms "expert physician reviewer" and "physician reviewer" have been defined, it is not necessary to define the term "non-physician reviewer" as the definition may not be sufficient to encompass all the different methodologies related to utilization review that are common business practices in the market. Finally, it appears that the commenter confuses the terms claims	Section 9792.6(l) defines the term "physician reviewer" to mean physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by any U.S. Jurisdiction, competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician's practice.

			administrator and non-physician reviewer. While the claims administrator is a business (i.e, "claims Administrator" is a self-administered workers' compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator for an insurer, a self-insured employer, a legally uninsured employer, a joint powers authority, or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity with which an employer or insurer contracts to conduct its utilization review responsibilities), the non-physician reviewer is an individual working for the claims administrator.	
Sections 9792.7, 9792.9	Commenter further states that since a "non-physician reviewer" is not defined, there is no requirement that this individual have any medical background. Commenter appears to object to having the non-physician discuss "applicable criteria" when the request for authorization "appears to be inconsistent" with these criteria and, furthermore, to "reasonably request appropriate additional information necessary to render a decision." Commenter states that as was previously noted, the term "non-physician reviewer" does not appear in subdivision (f) of 8 CCR § 9792.9. Commenter questions how does the non-physician reviewer do those things		Disagree. The statute (Labor Code 4610(e) and the proposed regulations (§§ 9792.7(b)(2), 9792.9(f)) are clear that only a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services can modify, delay or deny requests for authorization of medical treatment *"for reasons of medical necessity."* However, the regulations provide for flexibility in allowing the non-physician reviewer to, within the appropriate timeframes and in the appropriate cases in order to expedite	None.

	necessary to render a decision on the request when it does not appear that they are within the class of individuals mentioned in 8 CCR § 9792.9?		the utilization review process, discuss the request with the requesting physician including requesting further information when necessary. Then, within the delineated timeframes the case is moved on to the physician reviewer with the appropriate information to modify, delay or deny the request if necessary.	
Section 9792.9	Commenter also states that the proposed regulations create the potential of a dispute prior to a physician reviewing the request for authorization when it states that the non-physician reviewer may "reasonably" request "appropriate" additional information. Commenter raises the questions of what if the physician disagrees with the request, does it effect a denial or does it automatically trigger a dispute under Labor Code § 4062 prior to any review by a physician?		Disagree. The regulations are clear that the non-physician reviewer can ask for additional information within the specified timeframes (§9792.9(b)(2)). If the requesting physician refuses to provide the requested information, the non-physician reviewer forwards the request to the physician reviewer who will review and decide whether to modify, delay or deny, and then issue a decision. After the decision is issued by the physician reviewer, the dispute resolution process set forth in Labor Code section 4062 applies.	None.
General Comment	Commenter states that the goal of the Division is apparently to foster a dialogue between the provider and the reviewer. This is a worthy goal. It is not furthered, however, by trying to regulate every detail of that dialogue. Proposed 8 CCR § 9792.7(a)(2) requires the claims administrator to describe its review process. In this regard, commenter believes that there is no need for additional regulation. Commenter states that if the Division wants to		Disagree. It is believed that the further clarifying definitions and language in the regulations are sufficient to allow the public to understand the utilization review process and to adequately participate in the process.	None.

	encourage this dialogue to take place, then it should consider additions to 8 CCR § 9792.7(a)(2) language, such as, "The description of the processes for review shall include a statement that the claims administrator may contact the physician seeking authorization prior to a decision on whether to approve, deny, delay, or modify the request should questions arise as to whether the treatment is consistent with the medical treatment utilization schedule or whether there is adequate information supporting the request."			
Section 9792.9(f)	Commenter states that there are additional issues that arise from the definition and concept of an "expert reviewer". Commenter adds that given that the proposed regulations discuss the use of an "expert reviewer" solely within the context of when the *claims administrator* requires additional information prior to making a decision [8 CCR § 9792.9(f)(1)(C)] and given that the claims administrator can only approve the treatment, if there is any doubt as to whether to approve the treatment then the request should go to a physician for review. Commenter states that instead, the regulation contemplates a process whereby the claims administrator seeks additional guidance, in the form of an undefined "specialized consultation" from an "expert reviewer" before making his or her decision to approve, deny, delay, or modify a request. Commenter argues that this is not only contrary to statute, but is contrary to other provisions of the same regulation.		Disagree. Commenter misreads the proposed regulations. The definition of claims administrator includes the entity with which an employer or insurer contracts to conduct its utilization responsibilities. Thus, the regulation is clear that the non-physician reviews and gathers pertinent data, then a physician reviewer reviews and determines whether the request merits further review by an expert physician reviewer. The physician reviewer then passes the request on to the expert physician reviewer pursuant to the requirements of the statute. However, in the event that sections 9792.9(b)(2) and 9792.9(b)(2)(A) are not sufficiently clear, they have been amended to clarify to differentiate the usages of the terms "physician reviewer," "non-physician reviewer," and to substitute the word "provider"	sections 9792.9(b)(2) and 9792.9(b)(2)(A) have been amended as follows: 9792.9(b)(2) "If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a physician reviewer or a non-physician reviewer within five (5) working days from the date of receipt of the written request for authorization to make the proper determination. In no event shall the determination be made more than 14 days from the date of receipt of the

			with the words "requesting physician."	original request for authorization by the health care provider. 9792.9(b)(2)(A) "If the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the requesting physician, a physician reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested."
General comment.	Commenter states that the process outlined in 8 CCR § 9729.9 does not clearly result in a report by a utilization review physician. Commenter states that 8 CCR §§ 9729.9(f)(3) and 9729.9(f)(4) authorize the claims administrator to deny treatment, and to do so in the case of § 9729.9(f)(1)(A) upon receipt of necessary medical information - in other words without any physician review. Commenter argues that not only is this contrary to statute and as such lacking in statutory authority and consistency, it also would create a situation where if there was a dispute under Labor Code § 4062 there would be no UR physician's report, leaving only the applicant QME report for the judge to base a decision.		Disagree. Commenter misreads the proposed regulations. The proposed regulations provide for the claims administrator to approve the requests for authorization of medical treatment, for the non-physician reviewer to gather further information if necessary within the timeframes, and for the physician reviewer to modify, delay or deny requests for authorization in the utilization review report.	None.

Sections 9792.9(a)(1), 9792.9(g) (now re-lettered (h))	Commenter states that Labor Code § 4600.4 requires payers to have telephone access available until 5:30PM Pacific Time, encompassing daylight savings. Commenter states that the proposed regulations, 8 CCR § 9792.9(a)(1) address the issue of when a request for authorization is transmitted by facsimile after 5:30 PM Pacific Standard Time, and that this time requirement is reiterated in subdivision (g) of the same Section relating to telephone access for requests for authorization. Commenter states that this is contrary to Labor Code section 4600.4, and recommends that this be amended by removing the term "standard" from the text of the regulations.		Agree. Commenter is correct that Labor Code section 4600.4 provides that "a workers' compensation insurer, … that … pursuant to regulation requires, a treating physician to obtain … utilization review … shall ensure the availability of those services from 9 a.m. to 5:30 p.m. Pacific coast time of each normal business day."	Proposed §§ 9792.9(a)(1), 9792.9(g) (now re-lettered (h)) have been amended to delete the word "standard" from the text of the regulations. The sections now state: §§ 9792.9(a)(1) "For purposes of this section, the written request for authorization shall be deemed to have been received by the claims administrator by facsimile on the date the request was received if the receiving facsimile electronically date stamps the transmission, or the date the request was transmitted. A request for authorization transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day as defined in Labor Code section 4600.4 and in section 9 of the Civil Code. The copy of the request for authorization received by a facsimile transmission shall bear a notation of the date, time

				and place of transmission and the facsimile telephone number to which the request was transmitted or be accompanied by an unsigned copy of the affidavit or certificate of transmission which shall contain the facsimile telephone number to which the request was transmitted. The provider must indicate the need for an expedited review upon submission of the request. 9792.9(h) "Every claims administrator shall maintain telephone access from 9:00 AM to 5:30 PM Pacific Time, on normal business days, for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from health care providers requesting authorization for medical services after

				business hours. For purposes of this section "normal business day" means a business day as defined in Labor Code section 4600.4 and Civil Code section 9. In addition, for purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number for after business hours requests.
Section 9792.10(a)(3)	Commenter states that proposed 8 CCR § 9792.10(a)(3), stating that nothing in the dispute resolution process precludes the parties from agreeing to an internal UR appeal process, lacks statutory authority. Commenter states that Labor Code § 4610(g)(3) is clear and unambiguous that "(i)f the request is not approved in full, disputes shall be resolved in accordance with Section 4062."		Disagree. Many utilization review companies have their own internal appeal process. Participation in the utilization review company's appeal process pursuant to section 9792.10(a)(3) is voluntary, and the injured worker and injured worker's attorney have to be notified of the 20-day limit to file an objection to the utilization review decision in accordance with Labor Code section 4062.	None.
Section 9792.7(b)(3)	Commenter states that the introduction of non-physician reviewers in the proposed text of the regulations, 8 CCR § 9792.7(b)(3), as part of the utilization review determination to deny	**Susan Guyan**, Director of Employee Benefits, Chair of CCWC	Agree in part. We disagree that proposed section 9792.7(b)(3) allows the non-physician reviewer to deny requests for authorization of medical	None.

	treatment under any circumstances is contrary to Labor Code § 4610. Commenter recommends that the subdivision be stricken.	COSTCO March 22, 2005 Written comment	services. The section is clear that a non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. Further, the non-physician reviewer may approve requests for authorization of medical services, and may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision. However, the proposed regulations specifically state that only a physician may delay, modify or deny requests for authorization of medical treatment (section 9792.7(b)(2)). Commenter is correct that the proposed regulations should not provide for allowing the non-physician reviewer to deny requests for medical treatment under any circumstances. Thus, section 9792.9(b)(2)(A) has been amended to	Section 9792.9(b)(2)(A) has been amended as follows: "If the reasonable information requested by the claims administrator is not received within 14 days of

			state that only a physician may deny a request for authorization of medical treatment for lack of information.	the date of the original written request by the requesting physician, a physician reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested."
General comment	Commenter further states that for a denial of care to be binding, a certified California physician must provide a written statement to address the basis of the denial, and in the event a hearing is requested, the judge will have proper documentation in which to issue a ruling.		Disagree. The regulations do not provide for non-physicians to deny requests for authorization of medical treatment. Further, the statute only requires that the medical director have a California license. (Labor Code section 4610(e).) The statute does not require that the UR be conducted or the UR report be prepared by a California physician.	None.
General comment	Commenter states that the proposed regulations go beyond what is necessary. Commenter states that the regulations require the claims administrators to describe their review process in the UR plan. Commenter believes that the submission of the plan should be sufficient to determine that their standards of practice meet the timely authorizations or denial of care by expert medical providers. Commenter further states that regulations that muddy the system such as defining when to obtain a specialized consultation are not necessary. Commenter opines that the regulations should be limited to fostering utilization review protocols for efficient and		Disagree. The requirement that the claims administrator describe in its UR plan the review process is mandated by the statute. (Labor Code section 4610(f). Further the regulations do not specify when to obtain a specialized consultation. Pursuant to the statute, the regulations clarify when the timelines may be extended (Labor Code section 4610(g)(5), stating that The timeframe for decisions specified the regulations may only be extended by the claims administrator under the certain circumstances, including the	None.

	appropriate care.		need for a specialized consultation and review of medical information by an expert physician reviewer.	
Section 9792.6(g) (now re-lettered 9792.6(h)).	Commenter states that just as with the IMR regulations, the UR regulations should require that "expert reviewers" as defined in the regulations, should have no actual or perceived conflicts of interest with respect to the medical treatment services being evaluated or with the reviewing physician, utilization review medical director, or external utilization review organization contracted by the claims administrator to perform the utilization review.	**Steve Cattolica**, Director, Government Relations, CSIMS, CSPM&R and US Healthworks March 22, 2005 Written and Oral comments	Disagree. The review by an expert reviewer is not a separate process from the UR review process. A review by an expert reviewer is part of the same process, and the expert reviewer is paid by the same UR program.	None.
Section 9792.7(b)(3)	Commenter states that the "non-physician reviewer" as described in section 9792(b)(3) should meet minimum training standards and continuing education criteria to fulfill the role described in the regulations.		Disagree. A requirement of training and education is beyond the scope of the statute.	None.
Section 9792.7(c)	Commenter states that while some claims administrators may choose to hire a utilization review organization whose plan is already approved by the Division, it is standard practice for claims organizations to provide criteria and thresholds for review of treatment that may be different than the utilization review organization's original filing. Commenter further states that in addition to the "letter identifying the external utilization review organization" the claims administrator should be required to include a written description of any variations to that external utilization review organization plan and those variations should be scrutinized in the same manner as the original plan.		Agree in part. The regulations require the claims administrator to file its UR plan, and to follow such plan as filed. However, commenter is correct that the claims administrator should be required to re-file its plan when the plan is revised. Thus a new sentence has been added to section 9792.7(c) requiring the claims administrator file a new utilization review plan with the Administrative Director within 30 calendar days after the claims administrator either changes its utilization review plan or makes material modifications to the plan.	Section 9792.7(c) has been amended as follows: "The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative

				Director. In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has filed a complete utilization review plan with the Administrative Director. A new utilization review plan shall be filed with the Administrative Director within 30 calendar days after the claims administrator either changes its utilization review plan or makes material modifications to the plan." None.
Section 9792.9(b)(3)	Commenter does not agree with the requirement in section 9792.9(b)(3) which calls for communication to the requesting physician within 24 hours with initial communication by phone or facsimile, followed by written notice to the physician. Commenter believes that there is no reason for written notice to be delayed awaiting telephone contact. Commenter states that		Disagree. The telephone contact within 24 hours of the request required by the regulations is necessary in order to insure prompt delivery of medical treatment. The written confirmation, however, allows for completion of the process.	

	these two activities should occur concurrently and as soon as possible after a decision is reached.			
Section 9792.9(e) (now §9792.9(f))	Commenter states that the term "competent" in this section must be more specific. Commenter suggests that the reviewing physician should be a peer to the requestor, for example, the physician reviewer should be of the same specialty and sub-specialty if possible.		Disagree. Section 9792.9(e) states: "The review and decision to deny, delay or modify a request for medical treatment must be conducted by a physician, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice." The description of the qualifications of the reviewing physician is set forth in the statute at 4610(e), and to require that the physician reviewer be of the same specialty and sub-specialty would constitute a requirement outside the scope of the statute.	None.
Section 9792.9(g) (now §9792.9(h))	Commenter states that the requirements for telephone access and definition of normal business days should be required of all physician reviewers as well as the utilization review organization/claims administrator. This requirement is especially needed in the case of physician reviewers not domiciled in the Pacific Time Zone.		Agree in part. Labor Code section 4610(h) requires "[e]very employer, insurer, or other entity subject to this section [to] maintain telephone access to physicians to request authorization. Further, Labor Code section 4600.4 requires claims administrators to be available for "either utilization review or prior authorization … from 9 a.m. to 5:30 p.m. Pacific Coast time of each normal business day." Thus the requirements as set forth in the section 9792.9(h) are consistent with the statute. However, commenter is	Section 9792.9(g) has been re-lettered. The section is now Section 9792.9(h), and it now states: "Every claims administrator shall maintain telephone access from 9:00 AM to 5:30 PM Pacific Time, on normal business days, for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number

			correct that the subdivision incorrectly states "Pacific Standard Time." Thus the section is corrected for clarification purposes to delete the word "Standard," and to provide a reference to Labor Code section 4600.4.	available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from health care providers requesting authorization for medical services after business hours. For purposes of this section "normal business day" means a business day as defined in Labor Code section 4600.4 and Civil Code section 9. In addition, for purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number for after business hours requests."
Section 9792.9(j) (now §9792.9(k))	Commenter states that the information called for in 9792.9(j) (now re-lettered 9792.9(k)) should include the physician reviewer's actual state of licensure and his/her normal work location (the location from which he/she performs the reviews. Commenter states that there is a case of one physician who routinely		Agree in part. Normal business practices entail utilization review being conducted at a national level. However, it is not believed that the statute envisioned utilization review being conducted outside of the United States. To address this	Section 9792.9(j) has been re-lettered. The section is now Section 9792.9(k), and it now states: "The written decision modifying, delaying or denying

	reviews treatment requests from South America.		problem, section 9792.9(k) is being amended to require that the written decision must contain, among other information, a telephone number in the United States. This amendment should be cross-referenced to section 9792.6(h) and 9792.6(l) requiring that the physician be licensed by any U.S. Jurisdiction.	treatment authorization provided to the physician shall also contain the name and specialty of the physician reviewer and the telephone number in the United States of the physician reviewer. The written decision shall also disclose the hours of availability of either the physician reviewer or the medical director for the treating physician to discuss the decision which shall be at a minimum four (4) hours a week Pacific Time.
Section 9792.11	Commenter states that the audit process must allow DWC to audit files not only at the location of the claims administrator, but at the location of the external utilization review organization whose certified plan is being utilized by a claims administrator.		Disagree. Issues relating to utilization review penalties will be addressed in a separate regulation which is in the process of being drafted. This comment will be considered in connection with those regulations.	None.
Section 9792.6(e) (now re-lettered §9792.6(f))	Commenter states that under both federal and state law, physicians and hospitals are held to a more complete definition of emergency care than is provided in the proposed regulations. Under federal and state statutes, severe pain is a symptom that is clearly identified as a basis for qualifying as an emergency condition. Commenter believes that the language in section 9792.6(e) (now re-lettered section 9792.6(f)) does not adequately address this matter, and the exclusion of severe pain in the	**Neileen Verbeten**, VP, Center for Economic Services, California Medical Association March 22, 2005 Written comment	Disagree. Pain is not excluded form the coverage by this language as pain is a symptom. There is not need to emphasize pain as other symptoms can be equally important.	None.

	utilization review regulations places providers at substantial jeopardy of being denied payment for services properly rendered and required under law. Commenter proposes that the section be amended as follows: "Emergency health care services means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."			
Section 9792.6(f) (now re-lettered §9792.6(g)) and 9792.9(d) (now re-lettered 9792.9(e))	Commenter recommends that the definition of "expedited review" be amended to mean "utilization review conducted under an accelerated timeframe for a medical condition that does not require emergency health care services, but the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function." Commenter states that the definition of Expedited Review as stated in the regulations implies that treating a patient with a medical emergency should be subject to Utilization Review processes rather than treated as an emergency. Commenter states that §9792.9(d) of the proposed Utilization Review Standards provides up to 72 hours to respond to a request for Expedited Review, and points out the inconsistency of imposing a delay of up to 72 hours for a condition that the law		Agree in part. The definition of "expedited review" is set forth in the statute at 4610(g)(2), which states in relevant part that it takes place when injured worker's condition is such that the injured worker "faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function." The statute further provides the timeline for response to the request for authorization of medical treatment under these circumstances which is "72 hours after receipt of the	New section 9792.9(d) has been added to the regulations, which state: "The delivery of emergency health care services shall not be delayed pending the physician's request for authorization."

	requires a provider to immediately address.		information reasonably necessary to make the determination." However, we agree that the regulations should be clear that emergency services cannot be delayed pending the physician's request for authorization. Thus, new subdivision (d) has been added section 9792.9, which clearly states that "the delivery of emergency health care services shall not be delayed pending the physician's request for authorization."	
General comment	Commenter states that under Labor Code 4610(d) the employer or insurer or other entity is required to "employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. Section 2050 refers to "physicians and surgeons", those persons qualified as Medical Doctors (M.D.) and licensed by the Medical Board of California. Section 2450 refers to Doctors of Osteopathy, (D.O.) and licensed by the Board of Osteopathic Examiners. Commenter further states that section 4610 goes on to state that the "medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section." Commenter also notes that section 4610(e) states that only a licensed physician		Disagree. Violations of section 4610 will be addressed in separate penalty regulations which are in the process of being drafted.	None.

	acting within the scope of his/her practice and competent to evaluate the specific clinical issues involved may deny, delay or modify a request for authorization of a proposed plan of treatment. Commenter states that CMA has received reports of decisions to deny, delay or modify performed by individuals they do not believe meet these criteria. Commenter sets forth one example: one complaint included a denial on the use of medications by an anesthesiologist. Commenter notes that to comply with the law, any person who denies, delays or modifies an authorization must have the requisite knowledge to evaluate the treatment proposed and be acting within the scope of their license.			
Section 9792.6(g) (now §9792.6(h))	CMA believes the action of conducting prospective and concurrent utilization review constitutes the practice of medicine. Commenter believes that the expert reviewer, as authorized by Labor Code 4610(g)(5), is engaged in the performance of a medical decision and would have to be licensed under the provisions of Sections 2050 or 2450 of the Business and Professions Code just as the medical director of the utilization review program is required. Thus, CMA believes the proposed definition of Expert Reviewer falls short of the requirement of the statute, and suggests that section 9792.6(g) (now re-lettered 9792.6(h)) be amended to read as follows: "Expert reviewer" means a physician who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code, competent to evaluate		Disagree. The statute is clear that the medical director of the utilization review program must hold a California license. Section 4610(d) provides, in relevant part, "The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code." When discussing the physician reviewer (or expert physician reviewer) the statute states at section 4610(e), "[n]o person other than a licensed physician who is competent to evaluate the specific clinical issues involved … may modify, delay, or deny medical treatment for reasons of medical	None.

	the specific clinical issues involved in the medical treatment services and where these services are within the scope of the physician's practice, who has been consulted by the reviewing physician or utilization review medical director to provide specialized review of medical information."		necessity to cure and relieve." It is clear that although the statute specifically requires the medical director to have a California license, there is no such requirement for the physician reviewer or the expert physician reviewer.	
Section 9792.6(n) (now re-lettered §9792.6(q), and new 9792.6(b)	Commenter objects to the suggested language proposed in section 9792.6(q), and states that under the proposed regulations, a serious deficiency is established when the utilization review process is disconnected from the payment process. Commenter states that it understands that claim adjudication is not a utilization management function, but points out that health insurance in the commercial sector and in other governmental programs assumes that claims will be processed in accordance with utilization management authorizations given. Commenter states that CMA physicians have complained repeatedly about payment denials for authorized services. Commenter states that while CMA is not suggesting alternative language at this time, it expects that claims adjusters will be held responsible for payment of services that have been authorized and that audit functions will assure that carrier process is designed to accomplish that end.		Agree in part. In order to resolve the problem of claims administrators denying payment for authorized services, new section 9792.6(b) has been added to the proposed regulations. The section defines the term authorization as follows: "authorization" means appropriate reimbursement will be made for a specific course of proposed medical treatment set forth in the Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or in the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2, or in a narrative form containing the same information required in the DWC Form PR-2."	New section 9792.6(b) has been added to the proposed regulations to define the term authorization. It states that "authorization" means appropriate reimbursement will be made for a specific course of proposed medical treatment set forth in the Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or in the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2, or in a narrative form containing the same information required in the DWC Form PR-2."
Section 9792.7(b)(2)	Commenter states that in keeping with the above discussion on the practice of medicine, CMA asserts that the review of an authorization request that results in a decision to deny, delay or modify involves the practice		Disagree. As stated above, the statute does not require that the physician reviewer have a California license. Thus a license from any U.S. Jurisdiction is sufficient to meet the	None.

	of medicine and that §9792.7(b)(2) must clearly state that the evaluation of the specific clinical issues involved requires, at minimum, an unrestricted license to practice medicine in the state of California. Commenter proposes the following language for section 9792.7(2): "No person, other than a physician and surgeon who holds an unrestricted license to practice medicine in the state who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician's practice, may, except as indicated below, delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury."		requirements of the statute. The statute only requires that the medical director have a California license, and an expansion of this requirement will go beyond the scope of the statute.	
General comment	Commenter states that Elizabeth McNeil has previously submitted comments from CMA to the Division on guidelines to be included in Utilization Review Standards, and incorporates these comments by reference.		Disagree. Further clarification was requested by the Division from the commenter with respect to the comments allegedly submitted by Elizabeth McNeil. After response from commenter, it was determined that the comments referenced were submitted on December 12, 2004 by Robert Hertzka, President of CMA. These comments, however, were submitted in connection with the Medical Treatment Utilization Schedule rulemaking action. These comments will be addressed in connection with that rulemaking.	None.

Section 9792.9(d) (now §9792.9(e))	Commenter states that the regulations proposed in section 9792.9(d) (now 9792.9(e)), are important for expedited review. However, CMA believes that section 9792.9(d)(1) entails a portion of the definition for emergency services for which no delay is acceptable. CMA recommends the following language: "Prospective or concurrent decisions related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The provider must indicate the need for an expedited review upon submission of the request. Decisions related to expedited review refer to situations in which the normal timeframe for the decision-making process, as described in subdivision (b), would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function."		Disagree. As previously indicated, the definition of "expedited review" is set forth in the statute at 4610(g)(2), which states in relevant part that it takes place when injured worker's condition is such that the injured worker "faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function." This language is set forth in section 9792.9(e) in describing the situations requiring expedited review. Moreover, the process for expedited review as set forth in section 9792.9(e) is based on the requirements of the statute which provides the timeline for response to the request for authorization of medical treatment under these circumstances which is "72 hours after receipt of the information reasonably necessary to make the determination."	None.
Section 9792.9(e) (now §9792.9(f)	Commenter states that section 9792.9(e) (now section 9792.9(f)) refers to the qualifications of the reviewer who denies, delays, or modifies a request for medical treatment. Commenter points out the legal issues underlying this activity and calls for the clear		Disagree. As stated above, the statute does not require that the physician reviewer have a California license. The statute only requires that the medical director have a California license, and an expansion of this	None.

	statement that such activities are limited to an individual licensed under Sections 2050 or 2450 of the Business and Professions Code.		requirement is beyond the scope of the statute.	
Section 9792.10	Commenter indicates that it would be helpful to clarify the timeliness intent of section 9792.10(a)(2). Commenter inquires as whether the 20-days time limit is working days or calendar days.		Disagree. Section 9792.10(a)(1) makes reference to Labor Code section 4062. Labor Code section 4062 clearly sets forth the timeline for objections to decisions made pursuant to Labor Code section 4610, stating, in relevant part: "If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision." This reference in the Labor Code is clearly to calendar days, not working days.	None.
Section 9792.7(a)(3)	Commenter states that since the adoption of the utilization review standards regulations, occupational therapists in California have received countless denials for service even after prior authorization was granted. Commenter requests that section 9792.7(a)(3) be clarified to state that other protocols or standards, such as those for the provision of occupational therapy, may be included in the utilization review plans. Commenter adds that interim guidelines for the provision occupational therapy should be included in the regulations that consist of a prior authorization process, in which the indications for treatment and the expected progress shall be documented, and documentation of actual functional progress shall be required at	**Christine Wietlisbach, MPA, OTR/L, CHT, CWS**, President, Occupational Therapy Association of California, March 22, 2005 Written comment	Disagree in part. Commenter requests that interim guidelines for the provision occupational therapy should be included in the regulations is outside the scope of these regulations. The issue of whether the ACOEM Guidelines properly address physical modalities or whether there should be separate guidelines form physical modalities will be addressed when the Administrative Director adopts regulations adopting the medical treatment utilization schedule pursuant to Labor Code section 5307.27. However, the regulations have been	Section 9792.8(a)(2) has been amended, in relevant part, to state that "[t]reatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines." Further, a new section has been added at section 9792.8(a)(4) to state that "[n]othing in this section precludes authorization of medical treatment not included in the specific criteria disclosed under

	specified intervals as a condition of continued authorization for services.		amended at section 9792.8(a)(2) to state that treatment may not denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines. Further, a new section has been added at section 9792.8(a)(4) to state that nothing in this section precludes authorization of medical treatment not included in the specific criteria disclosed under section 9792.7(a)(3) Moreover, violations of section 4610 will be addressed in separate penalty regulations which are in the process of being drafted.	section 9792.7(a)(3).”
Section 9792.8(a)(2)	Commenter states that the regulations should include a formal instruction to insurance carriers not to use topical gaps in the ACOEM guidelines with regard to occupational therapy as grounds for denial of occupational therapy services. Commenter further states that the regulations should define what is meant by “other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.” Commenter further states that the regulations should include provisions detailing the process by which a provider may submit this documentation and how a claims reviewer is to evaluate the guidelines, and that interim guidelines for the provision occupational therapy should be included in the regulations that consist of a prior authorization process, in		Disagree in part. See response to comment above.	None.

Section 9792.8(a)(3)	which the indications for treatment and the expected progress shall be documented, and documentation of actual functional progress shall be required at specified intervals as a condition of continued authorization for services. Commenter states that even before these regulations went into effect, insurers have been denying claims by stating that occupational therapy services were not provided in accordance with ACOEM guidelines. Commenter states that the regulations should include a provision that requires claims administrators to not only cite the criteria or guidelines used, but also the rationale for the decision. Commenter further states that frequently payers only state that "the services provided do not appear to be in compliance with Labor Code Sections 4604.4 and 5307.27 regarding appropriate practices of medical care" as the reason for denying payment.		Disagree in part. The regulations already require at section 9792.8(a)(3) that the claims administrator provide to the requesting physician "the criteria or guidelines" used "in written form." Thus, the regulations require more than a mere citation of the guidelines used. See also response to comment above. However, the regulations have been amended at section 9792.8(a)(2) to state that treatment may not denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines. Further, a new section has been added at section 9792.8(a)(4) to state that nothing in this section precludes authorization of medical treatment not included in the specific criteria disclosed under section 9792.7(a)(3)	Section 9792.8(a)(2) has been amended, in relevant part, to state that "[t]reatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines." New section 9792.8(a)(4) has been added to the proposed regulations, stating: "Nothing in this section precludes authorization of medical treatment not included in the specific criteria disclosed under section 9792.7(a)(3)."
Section 9792.9(b)(3)	Commenter states that it is not clear from the proposed language whether the "clock" for the timeframes for written notification begins after the verbal or facsimile notification is made or whether the "clock" starts as soon as the decision is made. Commenter offers that Labor Code 4610 (g)(3)(A) is clear that these timeframes start as soon as the decision is made; not after the verbal or facsimile	**Peggy Hohertz,** Regulatory Compliance Analyst, Fair Isaac Corporation March 22, 2005 Written comment.	Agree. Section 9792.9(b)(3) has been amended to reflect that the timeline starts to run from the time the decision is made. Also the regulations were amended to reflect the accurate interpretation of Labor Code section 4610(g)(3) to reflect that while the decisions to modify, delay or deny the request for	Section 9792.9(b)(3) has been amended to read as follows: "Decisions to approve a physician's request for authorization prior to, or concurrent with, the provision of medical services to the injured worker shall be

	notification is made. Thus, commenter recommends that section 9792.9(b)(3) be amended to reflect that the timeline starts to run from the time the decision is made.		authorization must be communicated in writing to the requesting physician and employee, the decision to approve the request for authorization need only to be communicated to the requesting physician. Thus, section 9792.9(b)(3) was accordingly amended and new section 9792.9(b)(4) was added to the proposed regulations to reflect the correct interpretation of the statute.	communicated to the requesting physician within 24 hours of the decision. Any decision to approve shall be communicated to the physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review." New Section 9792.9(b)(4) states: "Decisions to modify, delay or deny a physician's request for authorization prior to, or concurrent with the provision of medical services to the injured worker shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician, the provider of

				goods or services identified in the request for authorization, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review."
Section 9792.9(f)(3) (now re-lettered §9792.9(g)(3)	Commenter recommends that section 9792.9(f)(3) be amended to reflect that the five-days timeline identified in the regulations refers to five working days consistent with Labor Code 4610 (g)(5).		Agree. Commenter is correct that Labor Code 4610 (g)(5) provides that upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), and that the timeframe in 4610 (g)(1) or (2) specifies a timeframe of five (5) working days.	Section 9792.9(g)(3) has been amended. The section now states: "Upon receipt of information pursuant to subdivisions (A), (B), or (C) above, the claims administrator shall make the decision to approve, modify, or deny the request for authorization within five (5) working days of receipt of the information for prospective or concurrent review. The decision shall be communicated pursuant to subdivision (b)(3)."
Section 9792.9(i)(8) (now re-lettered §9792.9(j)(3)	Commenter recommends that section 9792.9(j)(8) Include the following mandatory language:		Agree. The mandatory information set forth in section 9792.9(g)(8) is intended to assist the injured worker to contact an Information and	Section 9792.9(j)(3) has been amended, in pertinent part to state: "If you want further

	"If you want further information, you may contact the local state Information and Assistance office closest to you. Please see attached listing. [attach a listing of I&A offices and telephone numbers] or you may receive recorded information by calling 1-800-736-7401…" Commenter states that this change will permit claims administrators to provide a listing of all state Information and Assistance office locations and numbers. Commenter further states that a listing may be helpful to employees who travel on the job or who would prefer to visit a state Information and Assistance Office closer to where they work.		Assistance Officer if further information is required.	information, you may contact the local state Information and Assistance office closest to you. Please see attached listing (attach a listing of I&A offices and telephone numbers) or you may receive recorded information by calling 1-800-736-7401."
Section 9792.9(j) (now re-lettered §9792.9(k)	Commenter states that the requirements contained in section 9792.9(k) is not found in Labor Code 4610 such as the inclusion of the physician reviewer's name, specialty, telephone number and hours of availability. Commenter corrects for grammatical error the first sentence of the section regarding the request that the written decision contain the specialty of the physician reviewer. However, commenter opines that it would be simpler to include the name of the utilization review organization (claims administrator or external UR organization) and the hours of operation of the utilization review organization. Commenter believes that this change would also help show compliance with Labor Code 4610 (h) and facilitate communication regarding any internal appeals process. Commenter states that many reviewing physicians, and specifically all of their		Agree in part. We accept the grammatical correction offered by the commenter. However, we disagree with commenter's suggestion that the name of the utilization review organization (claims administrator or external UR organization) and the hours of operation of the utilization review organization be the only information required to be provided. Section 9792.9(k) is intended to facilitate communication between the reviewer and the requesting physician. Just as the reviewers are in active practice, so are the requesting physicians. Comments have been submitted by the requesting physicians stating that the UR reviewer calls and requests that the requesting physician get back	Section 9792.9(k) has been amended. The section now states: "The written decision modifying, delaying or denying treatment authorization provided to the physician shall also contain the name and specialty of the physician reviewer and the telephone number in the United States of the physician reviewer. The written decision shall also disclose the hours of availability of either the physician reviewer or the medical director for the treating physician to

	internal appeals physicians, are in active practice, so it is not a simple thing to include hours of availability on a specific physician reviewer.		to them immediately or the request will be denied. Some of these requesting physicians are, for example, practicing surgeons who cannot come to the phone immediately. The proposed section will be amended, however, to set forth a compromise under the circumstances. The section is amended to require that the written decision disclose the hours of availability of either the physician reviewer or the medical director for the treating physician to discuss the decision which shall be at a minimum four (4) hours a week Pacific Time.	discuss the decision which shall be at a minimum four (4) hours a week Pacific Time."
Section 9792.6(j) (now re-lettered 9792.6(m))	Commenter states that the definition of "prospective review" should be more specific in order to make a clear distinction between prospective review and concurrent review. Commenter recommends that this subsection be revised to read, "Prospective review means any utilization review conducted prior to the delivery of the requested medical services, except for utilization review conducted during an inpatient stay."	**Jose Ruiz,** Assistant Claims Rehabilitation Manager, State Compensation Insurance Fund March 22, 2005 Written comment.	Agree. Using the phrase "except for utilization review conducted during an inpatient stay" in the definition of prospective review makes a clear distinction between prospective review and concurrent review.	Section 9792.6(m) has been amended to read as follows: "Prospective review" means any utilization review, except for utilization review conducted during an inpatient stay, conducted prior to the delivery of the requested medical services."
Section 9792.9(a)(1) and (a)(2)	Commenter would like to change the timelines as delineated in these two subsections to reflect date of receipt as "the date stamped as received on the document the request was transmitted," and "on the date stamped as received on the document."		Disagree. The timelines are set forth in subsections are derived from the statute and the determination of "receipt" of the request for authorization is in accordance with common business practices. To accept commenter's approach would excuse bad business practices and	None.

			delay the timely provision of medical care to injured workers.	
Section 9792.9 (b)(2)(A)	Commenter states that this subsection does not indicate whether the reconsideration of a previously denied request by the claims administrator for lack of information provides the claims administrator with a new five-day timeframe. Commenter recommends that the timeframe for reconsideration of previously denied requests for authorization be consistent for previously delayed requests in which the claims administrator is allowed up to five days from the receipt of the appropriate information for prospective and concurrent reviews, and up to 30 days for retrospective reviews to render a final decision.		Disagree. The regulations have been amended to reflect that the claims administrator may not deny a request for authorization even for lack of information. Moreover, section 9792.9(g) is clear that the timelines may properly be extended when the claims administrator is not in receipt of necessary medical information reasonably requested. After receipt of the information, sections 9792.9(g)(3) and 9792.9(g)(4) clearly state the applicable timelines.	None.
Section 9792.9 (b)(3) §9792.9 (b)(4)	Commenter states this subsection provides that any decision to approve, modify, delay or deny a request for authorization may be communicated to the physician initially by telephone or facsimile, and that any communication by telephone should be followed by a written notice. Commenter states that the regulation does not indicate however whether a written notice is required to all other parties when the initial communication is sent to the physician via facsimile. Commenter recommends that when the initial communication to the physician is sent via facsimile, the claims administrator should also send a written notice to the injured employee and his or her attorney to advise them of the decision.		Accept in part. It is noted that section 9792.9(b)(3) is not a correct interpretation of the statute, and therefore is confusing to the public. Upon closer review of Labor Code section 4610(g)(3), decisions to approve a physician's request for authorization for medical services must be communicated to the requesting physician but there is no requirement that the decision be communicated to the injured worker as opposed to decisions to modify, delay or deny. However, it is believed that the regulations are clear that a telephone approval must be followed by a written confirmation. A facsimile approval however, does not need to be followed in writing	Section 9792.9(b)(3) has been amended to read as follows. "Decisions to approve a physician's request for authorization prior to, or concurrent with, the provision of medical services to the injured worker shall be communicated to the requesting physician within 24 hours of the decision. Any decision to approve shall be communicated to the requesting physician initially by telephone or facsimile. The communication by

			because the approval is already in written form.	telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review." New section 9792.9(b)(4) states as follows: "Decisions to modify, delay or deny a physician's request for authorization prior to, or concurrent with the provision of medical services to the injured worker shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician, the provider of goods or services identified in the request for authorization, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours

				of the decision for concurrent review and within two business days of the decision for prospective review."
Section 9792.6(c) (now re-lettered 9792.6(d))	Commenter states that the definition of concurrent review should be expanded to apply to situations beyond "inpatient stay" consistent with that used by the American Accreditation Healthcare Commission/URAC in its Workers' Compensation Utilization Management Standards. Commenter proposes that the definition be amended by adding "or course of treatment including outpatient procedures and services."	**Tami Cookman,** Legislative Assistant, Association of California Insurance Companies March 22, 2005 Written comment.	Disagree. The definition of concurrent review as "utilization review conducted during an inpatient stay," is a definition carefully crafted to harmonize the requirements of a concurrent review with Labor Code section (g)(3)(B), which requires that in the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. With regard to the outpatient treatment setting, it would be more appropriate to allow review of treatment using the ACOEM Guidelines which do not pertain to inpatient treatment.	None.
Section 9792.7(a)(3)	Commenter states that section 9792.7(a)(3) should be amended to reflect other treatment protocols or standards used for items clearly not covered by the promulgated schedule/guidelines. Commenter states that in some cases, those areas can be identified in advance and the claims administrators should be able to identify in advance those treatment protocols or standards they intend to rely on. Commenter further states that there will be other cases in which it will only be discovered		Agree in part. Section 9792.7(a)(3) has been amended to require the claims administrator to disclose in the utilization review plan the specific criteria utilized routinely in the review and throughout the decision-making process. Further, the section has been amended to require the claims administrators to describe in the utilization review plan the process used to review authorization	9792.7(a)(3) has been amended to read as follows: "A description of the specific criteria utilized routinely in the review and throughout the decision-making process, including treatment protocols or standards used in the process. A description of the process

	at the time of the treatment that the state promulgated schedule/guidelines do not address the proposed treatment, and requests that the language of subdivision (a)(3) should be amended to acknowledge this.		for treatment requests which fall outside the specified routine criteria.	used to review authorization for treatment requests which falls outside the specified routine criteria. A description of the personnel and other sources used in the development and review of the criteria, and methods for updating the criteria. Prior to and until the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition. The Administrative Director incorporates by reference the American College of Occupational and Environmental Medicine's Occupational Medicine Practice

				Guidelines (ACOEM), Second Edition (2004), published by OEM Press. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempress.com)."
Section 9792.8(a)(3)	Commenter indicates that section 9792.8(a)(3) states that the claims administrator may not charge an injured worker, his attorney, his physician or the provider of goods for a copy of the criteria or guidelines used to modify, delay, or deny the treatment request. Commenter states that if claims administrators are expected to provide the full guideline rather than the portion of the guideline relied upon, there are both copyright and contractual confidentiality agreements that make this difficult, if not impossible. Commenter further states that if it is only the portion of the guideline relied upon; there is a "fair use" use question under the copyright law. Commenter suggests that as long as the state is mandating the use of proprietary guidelines, the state, before placing requirements on claims administrators to provide the portion of guideline relied upon, ought to negotiate a "fair use" agreement with the holder of the copyright so that individual claims administrators do not receive conflicting positions from the holder of the copyright. Commenter further states that if the criteria or guidelines used by a claims administrator are those mandated by the state, there is no good		Disagree. The requirement that the physician and injured worker be provided with a copy of the criteria or guidelines used in the decision regarding the request for authorization is required by statute. (Lab. Code, § 4610(f).) See also, response to comments submitted by Julie K. Johnson, Assistant Vice-President of Medical and Disability Services, Liberty Mutual, dated December 8. 2004 above.	None.

	reason why the claims administrator should have to provide the criteria or guidelines to the injured worker's attorney and physician. Attorneys and physicians should be familiar with the contents and purchase their own copy as a cost of doing business involving workers compensation claims.			
Section 9792.9	Commenter states that there is an inconsistency in the time frames used in section 9792.9. Commenter indicates that some subsections use "five (5) days." Other subsections use "five (5) working days." Commenter suggests that in order to establish consistency, the Division should adopt the "five (5) working days" standard throughout the section. Commenter states that the use of five working days is reasonable, and the use of the five day standard in subsection (a)(2) would be particularly restrictive.		Agree in part. The regulations intended to allow the claims examiner a 5 working days timeframe to make a prospective or concurrent decision pursuant to the statute. (See, Labor Code section 9792.9(b)(1).) Further, the regulations intended to allow the claims examiner a 5 working days time frame to request further information after receipt of the request for authorization. (See, section 9792.9(b)(2).) Consistent with this timeframe, it is reasonable that the claims administrator may also have 5 working days to make a prospective or concurrent decision after receipt of the information requested as set forth in section 9792.9(g)(3). This, however, is totally unrelated to the requirement set forth in section 9792.9(a)(2) which refers to the timeline for receipt of the request for authorization. This section states that where the request for authorization is made by mail, and a proof of service by mail exists, the request shall be deemed to have been received by the	Section 9792.9(g) (3) has been amended to read as follows: "Upon receipt of information pursuant to subdivisions (A), (B), or (C) above, the claims administrator shall make the decision to approve, modify, or deny the request for authorization within five (5) working days of receipt of the information for prospective or concurrent review. The decision shall be communicated pursuant to subdivision (b)(3)."

			claims administrator five (5) days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.	
General Comment	Commenter states that the regulations should set standards for the Utilization Review Program that focus on the goals of eliminating outlier treatment except when necessary for the health of the injured workers. Commenter states that most UR programs identify triggering events or recommendations that qualify for a review, such as surgery, request for hospitalization, or physical therapy visits beyond a certain number. Commenter states that it is not supposed to be a system whereby every prescription, diagnostic test or physical therapy visit is reviewed.	**Doris Elaine Bough** Written Comment April 19, 2005	Disagree. The comment addresses general issues outside the scope of the regulations.	None.
General Comment	Commenter states that the Utilization Reviewers should be a foremost authority on the guidelines. Commenter further states that physician recommendations for guideline treatment or diagnostic test should be routinely approved if consistent with the guidelines, regardless of whether the physician specifies the exact page of the ACOEM guidelines that supports his or her recommendation.		Disagree. The comment addresses general issues outside the scope of the regulations.	None.
Section 9792.7	Commenter states that oversight of the UR process is lacking. Commenter states that section 9792.7 requires descriptions of their standards but has no apparent or implied feedback mechanism to insure that the plan is workable or acceptable to the regulatory agency.		Disagree. Oversight of the UR process will be accomplished by way of the UR penalties regulations which are in the process of being written in a separate rulemaking.	None.

Section 9792.11	Commenter states that enforcement of the UR is lacking. Commenter further states that section 9792.11 fails to specify how the Division plans to go about insuring that this most important benefit is properly administered. Commenter suggests that the Division set up an audit hotline so that injured workers can report delays in treatment that exceed the statutory time frame. Commenter further suggests that audit penalties be established to provide incentive to approve necessary treatment.		Disagree. Penalties in connection with the UR process will be addressed by way of the UR penalties regulations which are in the process of being written in a separate rulemaking. Commenter's suggestions will be considered in connection with this separate rulemaking.	None.
General Comment	Commenter appreciates the intent of the proposed regulations which is to encourage ongoing communication between the utilization review medical doctor and the treating physician.	**William Zachry,** Vice President Corporate Workers' Compensation – Safeway Oral Comment March 22, 2005	Agreed.	None.
	Commenter states that he would rather our regulations were less specific and he does not believe regulations concerning when to obtain specialized consultations are necessary.		Disagree. The regulations do not specify when a claims administrator may need to obtain a specialized consultation. They do, however, provide the timelines for this as required by the statute.	None.
	Commenter recognizes that there is a need to create a formal process because if there is litigation associated with the denial of care then there needs to be a factual trail that the Appeals Board can follow in order to make a determination.		Agreed. The formalized process is provided for by the statute.	None.
	Commenter believes that the utilization review process does not work well with cases involving a catastrophic injury.		Disagree. These are issues that will be addressed in a separate rulemaking in the medical treatment utilization schedule regulations.	None.

	Commenter strongly recommends that the UR regulations be implemented at the same time as the medical treatment utilization review regulations are developed. Commenter states that no one but a licensed medical physician should be allowed to deny treatment and that SB 899 was very clear on that point. Commenter believes that the proposed regulations are not consistent with the utilization review process outlined in the medical provider networks (MPNs) regulations.		Agree in part. Both rulemakings are being undertaken at the same time. Agree in part. The non-physician reviewer may gather necessary information for the physician reviewer. Disagree. Both rulemaking processes are going on at the same time. It is important to note that the MPNs must follow the UR regulations.	None. None. None.
General Comment	Commenter states that the regulations require that utilization review plans must contain a description of the specific criteria utilized in the review and throughout the decision-making process, including treatment protocols or standards used in the process and commenter support this. However, commenter states that she and her colleagues have received countless denials for services even after prior authorization is granted and that some of those examples are arbitrary certification periods. For example, a payer will give a length of time to provide care, but the therapist will not receive the authorization until perhaps two weeks after authorization and the time is already expired by the time treatment has started.	**Linda R. Botten** Occupational Therapist California Occupational Therapy Association Oral Comment March 22, 2005	Agree in part. There have been many complaints of claims administrators authorizing medical treatment and then refusing to pay for it under the excuse that the treatment provided is not cover by ACOEM. If the request for authorization has gone through the UR process, and the request has been approved, the provider is entitled to appropriate reimbursement for the proposed, approved medical course. A new definition has been added to the regulations to address this situation.	News section 9792.6(b) has been added to the regulations. The section states: "Authorization means appropriate reimbursement will be made for a specific course of proposed medical treatment set forth in the Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or in the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2, or in a narrative form containing the same information required in the DWC Form PR-2."

	Commenter states the utilization review standards must clarify or state that for all conditions or injuries not covered by the ACOEM practice guidelines, after the adoption of this law, authorized treatment shall be in accordance with other evidence based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based. Further commenter states that the regulations should include a formal instruction to insurance carriers not to use gaps in the ACOEM guidelines with regarding occupational therapy as grounds for denial of occupational therapy services. Commenter requests that the regulations should include a provision that requires claims administrators to not only cite the criteria for denial, but also the rational for their decision.		Agree in part. See response to comment submitted by Tami Cookman, Association of California Insurance Companies, dated March 22, 2005, above.	See action taken in connection with comment submitted by Tami Cookman, Association of California Insurance Companies, dated March 22, 2005, above.
General Comment	Commenter notes that the proposed regulations very clearly only allow for written authorizations. Commenter states that verbal authorizations should be allowed in approving obvious treatments without triggering the full UR process. Commenter notes that in the definitions that a written communications includes a facsimile; however, commenter requests that this definition be expanded to include all electronic communications, including but not limited to facsimiles. Commenter notes that there are requirements for the carrier to file a UR plan with the division but doesn't see any mechanism for reporting significant changes to the UR plan.	**Diane Przepiorski** Executive Director California Orthopedic Association Oral Comment March 22, 2005	Disagree. The statute provides for very strict timelines. It is more appropriate to have the request in writing to allow for better compliance with the statutory timelines. Disagree. See response to comment submitted by Eric Leinwohl, CID Management, dated March 22, 2005, above. Agree. See response to comment submitted by Steve Cattolica, CSIMS, CSPM&R and US Healthworks, dated March 22, 2005,	None. None. See action taken in connection with comment submitted by Steve Cattolica, CSIMS,

	Commenter suggests that there be a mechanism included stating that the carrier needs to report changes. Commenter states that there is a real problem with information sharing in the UR system. Commenter states that physicians routinely send in reports when they are providing services. However, commenter states that the results of diagnostic tests are placed in the injured worker's file, but it doesn't seem like the physician reviewers have access to that information when they receive a request for treatment. Commenter believes that the claims administrator for the carrier needs to take the responsibility to get medical information properly distributed to their UR staff to expedite review. Commenter states that treatment should not be denied merely because it is not included in the ACOEM treatment guidelines. Commenter states that the division needs to devote more resources to auditing treatment issues.		above. Disagree. The UR reviewer may only request those records necessary to conduct the review. Agree. It is incorrect to deny treatment on the basis that the treatment is not addressed in the ACOEM Guidelines. The treatment may be addressed in other guidelines. Disagree. With regard to the penalties issue raised by the commenter, this will be addressed in the presently undergoing UR violation penalty regulations rulemaking.	CSPM&R and US Healthworks, dated March 22, 2005, above. None. Section 0792.8(a)(2) has been amended to add the following sentence: "Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines." None.
General Comment	Commenter states that the penalty provisions of the utilization review regulations are extremely important.	**Mark Gerlach, CAAA** Oral Comment March 22, 2005	Disagree. With regard to the penalties issue raised by the commenter, this will be addressed in	None.

	Commenter stresses that the regulations should provide mechanisms so that the employer/insurer/third party administrator has a chance to make a determination as to the medically appropriateness, but to also insure that the decision will be made promptly, timely and that care will be provided in a timely manner. Commenter states that the testimony given at the hearing confirms that this in not happening in too many cases. Commenter believes that the proposed regulations contradict that the 14-day time limit that is in the law is a 14-day time limit and that in no event shall the decision be reached in more than 14 days. Commenter suggests that authorization be allowed to be provided via electronic transmission. Commenter suggests including a requirement that as soon as an adjustor is notified of the change in physician that they must notify that physician of the fax number and/or address to send requests for authorization.		the presently undergoing UR violation penalty regulations rulemaking. Disagree. See response to comment submitted by J. David Schwartz, California Applicants' Attorneys Association, dated March 21, 2005. Disagree. See response to comment submitted by Eric Leinwohl, CID Management, dated March 22, 2005, above. Disagree. It is more reasonable to allow the request for authorization to trigger the exchange of information.	None. None. None.
Section 9792.8	Commenter is concerned that it is a violation of copyright laws to provide written copies of the relevant sections used to deny treatment.	**Philip M. Vermeulen** Sr. Vice President Kammerer & Company Oral Comment March 22, 2005	Disagree. See response to comment submitted by Julie K. Johnson, Assistant Vice-President of Medical and Disability Services, Liberty Mutual, dated December 8. 2004, above.	None.